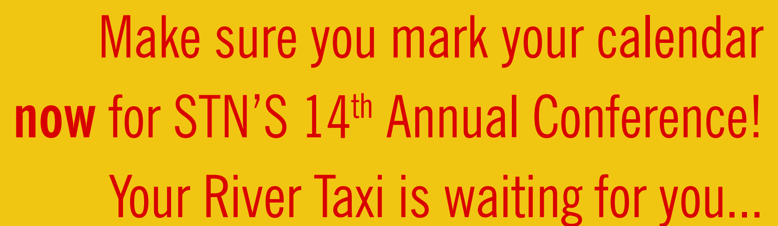
SOCIETY OF TRAUMA NURSES 13TH ANNUAL CONFERENCE

April 7–9, 2010

Hilton Orlando
6001 Destination Parkway
Orlando, Florida 32819
(407) 313-4300

CONFERENCE SYLLABUS



March 30 – April 1, 2011
Grand Hyatt San Antonio
San Antonio, Texas
www.grandsanantonio.hyatt.com

A World of Discovery

SOCIETY OF TRAUMA NURSES 13TH ANNUAL CONFERENCE

April 7–9, 2010
Hilton Orlando
Orlando, Florida

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STN

SOCIETY OF TRAUMA NURSES

WELCOME TO THE 13TH ANNUAL SOCIETY OF TRAUMA NURSES CONFERENCE DISCOVER THE WORLD OF TRAUMA

Welcome to Orlando, Florida, a city of spectacular scenery, delightful theme parks and a vast array of restaurants and hotels. We are pleased you are able to join us at our 13th Annual Conference of the Society of Trauma Nurses. The Annual Conference Committee has done a wonderful job of planning this meeting for you with a diverse collection of speakers, presentations and forums. Consider connecting or reconnecting with your favorite Special Interest Group (SIG). They have some interesting and informative meetings scheduled for you. Visit the vendors and learn about new and improved products to assist you and your trauma colleagues in running a more efficient trauma service and providing optimal care to you patients. Have a great time at this year's conference and embrace "The World of Discovery" by:

Reaching out and meeting new people….
Attendees at this year's conference come from all over the United State and other countries too. You represent the continuum of trauma care, trauma systems, and trauma support services. You cross the continuum of urban, suburban and rural care and systems. You focus on general and specialty populations. You span several generations of trauma providers. Take this opportunity to get to know as many of the attendees as you can. Learn from each other. Collect business cards and draw on your new resources when questions or challenges arise at your workplace. Also, be open to helping new colleagues when they contact you for advice or assistance. Do attend a SIG meeting and explore what benefits you can reap from joining a SIG but, equally important, what you can contribute. Don't be shy—stretch a little outside of your comfort zone.

Maximize your "take home" materials and information….
This conference is very rich in its content and speakers. From learning about the experiences of recent disaster responders and about the fine points of trauma resuscitation and clinical nursing to discussing the integration of trauma quality indicators in the culture of safety there's something for everyone. Take advantage of all that is available to you and of special interest to you. Share your perspective and experiences in interactive sessions. Browse the poster sessions and spend time with the authors to both learn from them but also to gain ideas for your own poster or abstract submission for next year's conference.

Get involved in STN…..
Join a SIG. Get familiar with ever expanding features and benefits of the STN website. Think about getting involved in STN nationally and talk to current members of the STN Board of Directors (wearing ribbons on their name badges) about your ideas for committees or projects. We are focused on succession planning for the STN Board to remain vital and relevant. Get involved and be a part of the dynamic process.

Please join me in thanking the Annual Conference Program Committee for creating this excellent conference. Have a great time at the 13th STN Annual Conference.

Sincerely,

Susan A. Cox, RN, MS, CPEN, PHN
President, STN

GREETINGS FROM THE CONFERENCE COMMITTEE

On behalf of the Society of Trauma Nurses (STN), the Conference Committee welcomes you to Orlando, to **A WORLD OF DISCOVERY**, our 13th Annual STN conference. In response to your evaluations and requests, we bring you a broad array of trauma topics and presenters with more CE opportunities, including CE during the Special Interest Group (SIG) meetings and during the welcome reception on Thursday afternoon.

During this week's voyage of discovery, leaders in trauma care will share the latest in innovative and evidence-based practice and you'll have opportunities to meet and greet with peers from around the globe. The goal of this conference is to address STN's core values:

- Commitment to trauma care
- Service to trauma patients, families, and society
- Belief in a multidisciplinary trauma team
- Visionary trauma leadership

This is your conference, and these are challenging financial times, so please make your needs heard by completing the course evaluation forms. This allows us to respond to your requests and provide you with an educational offering that combines both quality and value.

We send special thanks to the following:

- The faculty, moderators, and SIG program planners who have generously shared their time and expertise. We couldn't do this without you.
- The exhibitors and sponsors who attend and support this program. As always, they bring cutting-edge technology, products, and applications that are uniquely suited to trauma. Please take time to visit the exhibits, and learn about the newest adjuncts to trauma care.

We're **still going GREEN**, so you'll notice a decrease in the use of paper throughout this event. This syllabus includes an agenda, session abstracts, and notes pages. Presentations will be available for download after the conference. Conference registrants will receive an email with instructions on how to access the presentations.

All the best to all of you, as you network with your peers and share the experience of this remarkable conference,

The Conference Program Committee

Madonna Walters, MS, RN **Conference Chair** St. Joseph Mercy Hospital Ann Arbor, MI	Vicki Bennett, RN, MSN, CEN, CCRN Scottsdale Healthcare - Osborn Scottsdale, AZ	Marie Dieter, MSN, RN, PHRN, CEN Easton Hospital Easton, PA
Holly Bair, RN, MSN, NP **Conference Co-Chair** William Beaumont Hospital Royal Oak, MI	Ann Hoover, RN Maricopa Integrated Health Systems Gilbert, AZ	Janice Delgiorno, MSN, RN, CCRN, ACNP Cooper University Hospital Camden, NJ
Mary Jo Pedicino, MSN, RN The Children's Hospital of Philadelphia Philadelphia, PA	Dianna Liebnitzky, MS,BSN, LNCC, CEN Holmes Regional Medical Center St. Cloud, FL	Tom Ellison, RN, MSN, CCRN Treasure Coast Trauma Center at Lawnwood Regional Medical Center Fort Pierce, FL
Sue Cox, RN, MS, CPEN, PHN Rady Children's Hospital & Health Center San Diego, CA	Deborah Harkins, RN, BSN, MBA, CCRN University of Michigan Health System Ann Arbor, MI	Pat Manion, RN, MS, CCRN, CEN Genesys Regional Medical Center Grand Blanc, MI

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

March 8, 2010

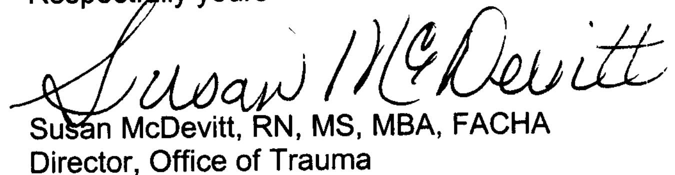
Dear Guests:

As Director, Office of Trauma for the trauma system at the Florida Department of Health, I would like to welcome you to our great state, and in particular, to the city of Orlando. We are pleased that the Society of Trauma Nurses has chosen Orlando to host their 13th Annual Conference. We hope you allow time for networking and enjoying all Orlando has to offer.

The Florida Trauma System primary goal is to facilitate, promote, and ensure that residents and visitors in Florida receive quality trauma care through planning, preparedness and quality assurance. This responsibility includes efforts to promote improvements through education and research. These are challenging times in healthcare, and we commend you for your ongoing commitment to learn and grow as professionals. Your valuable contributions to trauma care are gratefully acknowledged and respected.

Once again, welcome to Florida and enjoy the conference!

Respectfully yours



Susan McDevitt, RN, MS, MBA, FACHA
Director, Office of Trauma

SM/slh

Office of the State Surgeon General
4052 Bald Cypress Way, Bin A00 • Tallahassee, Florida 32399-1701

COURSE SCHEDULE-AT-A-GLANCE

WEDNESDAY, APRIL 7, 2010 – PRE-CONFERENCE SESSIONS	
7:45 AM – 4:30 PM	***TRAUMA OUTCOMES AND PERFORMANCE IMPROVEMENT COURSE (TOPIC) –*** *LAKE DOWN* Kathleen Martin, MSN, RN, CCRN and Kate Fitzpatrick, RN, MSN, CRNP-BC
8:00 AM – 4:00 PM	***OPTIMAL TRAUMA CENTER ORGANIZATION AND MANAGEMENT COURSE*** *– LAKE GEORGE* Frank Mitchell, III, MD, MHA, FACS; Judy Mikhail, RN, MSN, MBA; Amy Koestner, RN, MSN
12:20 PM – 4:35 PM	***GETTING STARTED: A PRIMER ON TRAUMA RESEARCH & EVIDENCE-BASED PRACTICE*** *– LAKE HART*
12:30 PM – 4:35 PM	***DISCOVER THE WORLD of PEDIATRIC TRAUMA*** *– LAKE MONROE*
12:30 PM – 4:35 PM	***MANAGING THE NEUROTRAUMA PATIENT - FROM ADVANCED PRACTICE TO OUTCOMES*** *– LAKE CONCORD*

THURSDAY, APRIL 8, 2010– FULL CONFERENCE SESSIONS				
OPENING SESSION & WELCOME – Leadership & Collaboration – *ORANGE BALLROOM E-G*				
7:30 AM – 8:30 AM	**PRESIDENT'S ADDRESS & Annual Meeting** – Sue Cox, RN, MSN, CPEN, PHN -STN President			
8:30 AM – 9:00 AM	**Advancing Collaborative Trauma Care** – Ernest Block, MD, MBA, EMT-P, FACS, FCCM			
9:15 AM – 10:15 AM CONCURRENT SESSIONS	RURAL TRAUMA SYSTEMS – **Injury Risk in Rural Communities: Perception versus Reality –** Mary Aitken, MD, MPH *LAKE CONCORD*	DISASTER MANAGEMENT – **Top 10 Lessons Learned from Recent Disasters** Michele Ziglar, MSN, RN *LAKE HART*	**ORAL PRESENTATIONS – Oral Abstract Winners** Research *LAKE GEORGE*	CHALLENGING CASES – **Delirium & Psychosis in the ICU –** Jonathan Cohen, MD *LAKE DOWN*
10:30 AM– 11:30 AM CONCURRENT SESSIONS	**PHARMACOLOGY – Recombinant Factor VIIa: Separating Fact from Fantasy** Laura Criddle, PhD, RN *LAKE CONCORD*	PEDS – **Fetal Trauma– The Other Side of Trauma in Pregnancy** Cindy Blank-Reid, RN, MSN, CEN *LAKE HART*	**ORAL PRESENTATIONS – Oral Abstract Winners** Evidence-Based Practice *LAKE GEORGE*	PREVENTION – **What Makes an Alcohol Screening & Brief Intervention Program Successful?** - Sydney J. Vail, MD, FACS *LAKE DOWN*
11:00 AM – 1:15 PM	**GRAND OPENING of EXHIBIT HALL - LUNCH in the EXHIBIT HALL – View Posters** – Start your Treasure Hunt – *ORANGE BALLROOM A-D*			

Room/ Start Time	**Special Interest Groups (SIGs) & Committees – CE opportunities**	
1:30 PM – 4:00 PM	**1:30 PM - 3:00 PM**	**3:00 PM – 4:00 PM**
LAKE HIGHLAND	**Neurotrauma SIG**	**Journal of Trauma Nursing - Committee**
LAKE LUCERNE	**Injury Prevention SIG**	**Membership Committee**
LAKE CONCORD	**Pediatric SIG**	**Pediatric Committee**
LAKE HART	**Advanced Practice SIG**	
LAKE GEORGE	**Military SIG**	**Disaster Management Committee**
LAKE FLORENCE	**Rural SIG**	**Legislation and Public Affairs Committee & SIG**
LAKE MONROE	**Education Committee**	**TOPIC Committee**
LAKE DOWN	**ATCN Executive Committee**	**ATCN Open Forum**
4:00 PM – 6:30 PM	**BRAIN TEASERS & PALATE PLEASERS** - Reception, Poster Judging, & small group CE session in the EXHIBIT HALL – *ORANGE BALLROOM A-D*	

FRIDAY, APRIL 9, 2010 – FULL CONFERENCE SESSIONS – *ORANGE BALLROOM E-G*	
7:00 AM – 8:00 AM	**The Ideal ACS Verification Site Visit: What would it take?** Frank "Tres" Mitchell, III, MD, MHA, FACS – Chair, VRC/ACS
8:05 AM – 9:30 AM ***Quality & Safety***	• **Monitoring Compliance with Clinical Practice Guidelines -** Donald Jenkins, MD, FACS • **Integrating Trauma & Other Quality Indicators within a Culture of Safety** – Kate Fitzpatrick RN, MSN, CRNP-BC
9:30 AM – 10:00 AM	Break - EXHIBITS OPEN – *ORANGE BALLROOM A-D*
10:05 AM – 11:30 AM ***Challenging Patients***	• **Variances in TBI Care Among Civilian and Combat Trauma Victims -** Kimberly Meyer, MSN, ACNP-BC, CNRN • **Ethics and Trauma: Tough Decisions at Difficult Times -** Sydney J. Vail, MD, FACS
11:45 AM – 1:00 PM	LUNCHEON and **DISTINGUISHED LECTURESHIP –** Frank "Tres" Mitchell, III, MD, MHA, FACS - *FLORIDA BALLROOM 1-4*
1:00 PM – 1:30 PM	Poster-viewing & networking - EXHIBITS OPEN – *ORANGE BALLROOM A-D*
1:30 PM – 3:15PM ***Resuscitation***	• **Role of the Nurse in Trauma Resuscitation –** Michelle Ziglar, MSN, RN • **Hemoglobin Targets – Where's the Evidence? –** Judy Mikhail, RN, MSN, MBA • **Trauma Resuscitation: The Finer Points** - Donald Jenkins, MD, FACS
3:15 PM – 3:25 PM	Break
3:30 PM – 4:30 PM ***RAPID FIRE – Special Populations***	• **Fall Prevention Clinics for Seniors: Cost-effective Programs that Work** – Pat Manion, RN, MS, CCRN, CEN • **How Culture Affects Injury Patterns – A Look at the Amish** – Susan Rzucidlo, MSN, RN • **Is Child Abuse Being Missed at Adult Trauma Centers?** - Karen Macauley, RN, MEd
4:30 PM	Closing remarks – Sue Cox, RN, MS, CPEN, PHN

CONFERENCE INFORMATION

Attendee Roster

Included with your registration materials is a printed attendee roster current as of **March 30, 2010**. We invite you to use this valuable resource to network with your peers during and after the conference. Please respect the individuals' contact information and utilize this resource for professional purposes only. **A final attendee roster will be distributed electronically after the conference.**

Badges

Only registered attendees, faculty and exhibitors are permitted to attend the 13th Annual STN Conference. Badges must be worn at all functions.

For easy access to session and events and as a courtesy to other attendees and exhibitors, please be sure your name and other information printed on your badge are clearly visible and not covered by pins or stickers.

Continuing Education Certificates

Pre-Conference Sessions – Certificates for the pre-conference sessions will be **available at the end of the session** to all participants that successfully complete their course and evaluation forms.

Conference Breakout and Plenary Sessions & Optional CE – Certificates for the concurrent sessions, plenary sessions and optional CE sessions will be **emailed to all participants** that successfully complete their course and evaluation forms.

Trauma Management Updates (Exhibitor-Sponsored CE) - Certificates for the Trauma Management Updates (exhibitor-sponsored CE) will be **emailed to all participants** that successfully complete their course and evaluation forms.

Conference Attire

Attire for the conference is business casual for all events. Feel free to be comfortable in slacks, polo shirts, sweaters, blazers, blouses and most importantly, comfortable shoes.

Remember meeting rooms tend to be cool. We recommend wearing layers to ensure your comfort.

Conference Evaluations

Pre-Conference Sessions – Evaluations will be distributed at the end of the session. Please be sure to complete the form and return it to the session moderator before leaving.

Conference Breakout and Plenary Sessions & Optional CE – Evaluations are included in the registration packets. Completed forms can be turned in at the registration desk or in the baskets labeled EVALUATION at the exit of each session room.

REMEMBER - BRING YOUR EVALUATIONS WITH YOU EACH DAY!!

Trauma Management Updates (Exhibitor-Sponsored CE) – The exhibitor-sponsored CE session evaluations will be distributed by the vendors. Be sure to complete your evaluation and turn it in with your CE card. See the **Trauma Management Updates** section for more information!

Conference Promotional Photos

STN Conference registration implies consent that any pictures taken during the conference can be used for conference coverage and promotional purposes and that STN is able to use your likeness without remuneration.

Courtesy

As a courtesy to the speakers and other participants, **please turn off all communication equipment** (i.e. cell phones, pagers, etc.) during the conference sessions.

Handouts

The Conference Syllabus includes session objectives and notes pages. Access to the full conference session presentations will be distributed via email within two weeks of the completion of the conference. The email will include a link and instructions on how to access the presentations.

Nursing Continuing Education Contact Hours

Nursing continuing education contact hours are provided by the Society of Trauma Nurses, a provider approved by the California Board of Registered Nursing with the provider number 11062. The following is a list of contact hours for applicable sessions:

Course	Contact Hours
TOPIC	9.3
Optimal Trauma Center Organization and Management Course	8.1
Getting Started: A Primer on Trauma Research & Evidence Based Practice	4.8
Discover the World of Pediatric Trauma	4.6
Managing the Neurotrauma Patient – From Advanced Practice to Outcomes	4.6
Conference Breakout and Plenary Sessions	12.3
Optional CE during SIG Meetings	1.0
Trauma Management Updates - Optional Exhibitor-Sponsored CE during Reception	1.2

Optional CE - Special Interest Group (SIGs)

The Society's **SIGs** have evolved to meet the needs of a membership with specialized interests and needs, through targeted information and education. **All STN members** are welcome and encouraged to join with those who have similar interests, and attend any of the SIG meetings, even if this is your first time. This year, all of the SIGs will be offering **1.0 contact hour of continuing education (CE) credit.**

Each **SIG** meets individually to provide an opportunity for the chairs to update members on activities and discuss strategies for developing projects, programs, and/or services that meet the needs of the specific group. **See the Course-Schedule-at-a-Glance** specific meeting times and locations.

Registration Desk and Information Center

The registration desk is located outside in the Orange Foyer on the lower level of the Hilton Orlando. Please visit the registration desk to ask questions about the conference, membership, STN sponsored courses, etc. You may also ask the STN staff or a member of the conference committee for assistance.

Hours of Operation:

Tuesday, April 6	3:00 PM – 6:00 PM
Wednesday, April 7	7:00 AM – 5:30 PM
Thursday, April 8	6:30 AM – 6:30 PM
Friday, April 9	6:30 AM – 4:30 PM

Registration Fees

Registration for the STN Annual Conference includes:

- Two days of educational sessions and access to the exhibit hall
- Special Interest Group (SIG) sessions
- Thursday's Welcome Reception
- Thursday's continental breakfast and annual meeting luncheon
- Friday's continental breakfast and luncheon with speaker
- Opportunity to talk one-on-one with the editor of the Journal of Trauma Nursing

Additional fees are required for the Pre-conference sessions on Wednesday, April 7, 2010

Schedule-at-a-Glance

Tuesday, April 6, 2010

3:00 PM	–	6:00 PM	**Registration Open**	*ORANGE FOYER*

Wednesday, April 7, 2010 – Pre-Conference Sessions

7:00 AM	–	5:30 PM	**Registration Open**	*ORANGE FOYER*
7:45 AM	–	4:30 PM	**Trauma Outcomes Performance Improvement Course (TOPIC)**	*LAKE DOWN*
8:00 AM	–	4:00 PM	**Optimal Trauma Center Organization & Management Course**	*LAKE GEORGE*
12:20 PM	–	4:35PM	**Getting Started: A Primer on Trauma Research & Evidence-Based Practice**	*LAKE MONROE*
12:30 PM	–	4:35PM	**Discover the World of Pediatric Trauma**	*LAKE CONCORD*
12:30 PM	–	4:35PM	**Managing the Neurotrauma Patient: From Advanced Practice to Outcome**	*LAKE HART*

Thursday, April 8, 2010 – Full Conference Sessions

6:30 AM	–	6:30 PM	**Registration Open**	*ORANGE FOYER*
6:30 AM	–	8:00 AM	**Continental Breakfast**	*ORANGE FOYER*
7:30 AM	–	9:00 AM	**Opening Session – President's Address & Annual Meeting**	*ORANGE E-G*
9:15 AM	–	10:15 AM	**Concurrent Sessions I**	
			Injury Risk in Rural Communities: Perception versus Reality	*LAKE CONCORD*
			Top 10 Lessons Learned from Recent Disasters	*LAKE HART*
			Oral Abstract Winners - Research	*LAKE GEORGE*
			Delirium & Psychosis in the ICU	*LAKE DOWN*
10:15 AM	–	10:30 AM	**Break**	*ORANGE FOYER*
10:30 AM	–	11:30 AM	**Concurrent Sessions II**	
			Recombinant Factor VIIa: Separating Fact from Fantasy	*LAKE CONCORD*
			Fetal Trauma– The Other Side of Trauma in Pregnancy	*LAKE HART*
			Oral Abstract Winners - Evidence-Based Practice	*LAKE GEORGE*
			What Makes an Alcohol Screening & Brief Intervention Program Successful?	*LAKE DOWN*
11:00 AM	–	6:30 PM	**Exhibit Hall Open**	*ORANGE A-D*
11:30 AM	–	1:15 PM	**Lunch in the Exhibit Hall – Poster Viewing**	*ORANGE A-D*
1:30 PM	–	4:00 PM	**Special Interest Groups (SIG) Meetings (CE Available) & Committee Meetings**	*SEE COURSE SCHEDULE-AT-A-GLANCE*
4:00 PM	–	6:30 PM	**Brain Teasers & Palate Pleasers - Welcome Reception, Poster Judging & Exhibitor Sponsored CE sessions**	*ORANGE A-D*

Friday, April 9, 2010 Full Conference Sessions

6:30 AM	–	4:30 PM	**Registration Open**	*ORANGE FOYER*
7:00 AM	–	8:00 AM	**Daybreak Plenary Session I & Continental Breakfast**	*ORANGE E-G*
8:05 AM	–	9:30 AM	**Plenary Session II**	*ORANGE E-G*
9:30 AM	–	10:00 AM	**Break - Exhibit Hall Open**	*ORANGE A-D*
10:05 AM	–	11:30 AM	**Plenary Session III**	*ORANGE E-G*
11:45 PM	–	1:00 PM	**Lunch & Distinguished Lecturer**	*FLORIDA 1-4*
1:00 PM	–	1:30 PM	**Poster Viewing & Networking – Exhibit Hall Open**	*ORANGE A-D*
1:30 PM	–	3:15 PM	**Plenary Session IV**	*ORANGE E-G*
3:15 PM	–	3:25 PM	**Break**	*ORANGE FOYER*
3:30 PM	–	4:30 PM	**Plenary Session V**	*ORANGE E-G*
4:30 PM			**Closing Remarks**	*ORANGE E-G*

SEE WEDNESDAY, THURSDAY & FRIDAY SECTIONS FOR PROGRAM DETAILS

Thank you to our 2010 Sponsors –

Water Bottles & Pens

Conference Bags

Trauma Management Updates (Optional Exhibitor-Sponsored CE)

For the first time this year, several exhibitors are offering continuing education content at their booths. These breakout sessions will collectively comprise of a session called Trauma Management Updates. Individual breakouts will be short – 17 minutes including Q&A – and nurses must attend at least three (3) of the sessions to earn one (1) CE contact hour.

A continuing education card for the Trauma Management Updates is included in your registration packet. **The instructor must initial your card at the end of each session** and you must ***complete an evaluation of each breakout session*** you attend. Both the card and the evaluations can be turned in at the registration desk or in the basket marked EVALUATIONS located in the exhibit hall.

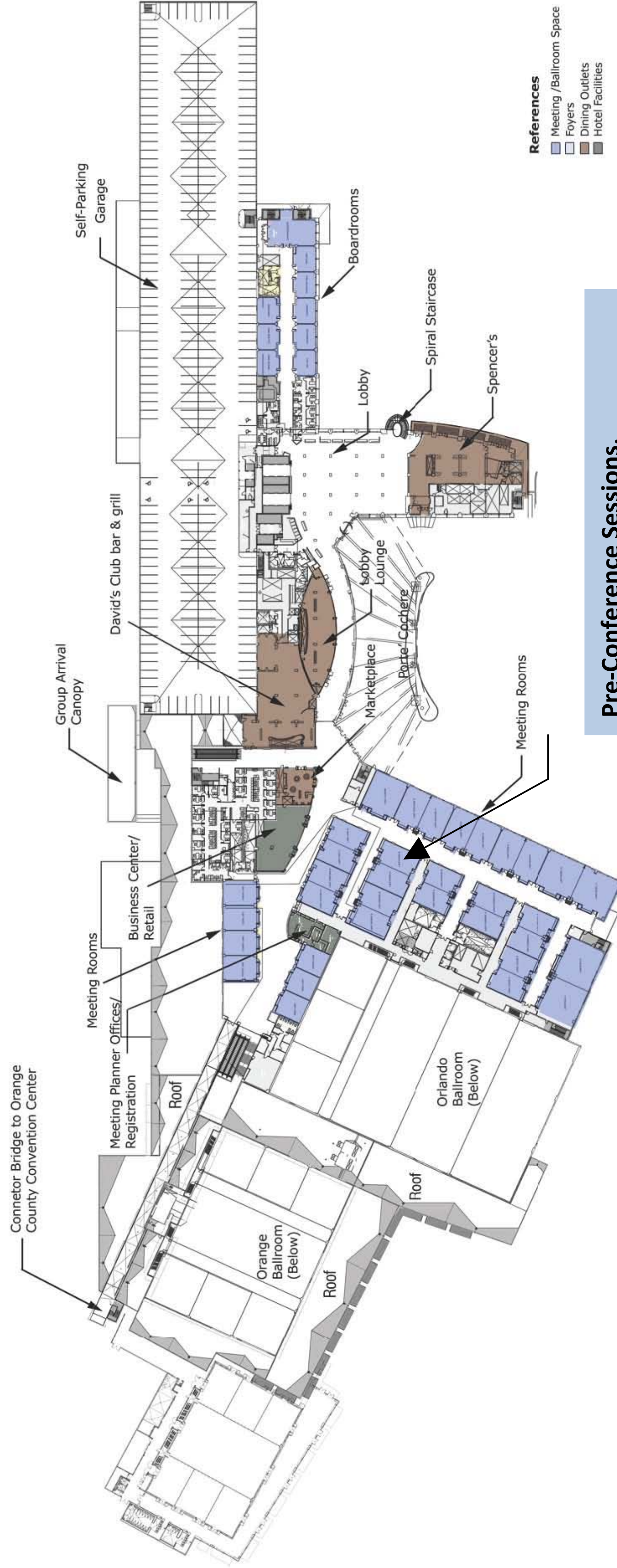
REMEMBER – **you must also complete the sign-in sheet for each session you attend. The sign-in sheets and cards will be cross referenced to verify attendance.**

Continuing education certificates will be emailed to you after the conference.

Treasure Hunt

ARR!!! Grab a mate, lass or scallywag and start searching for the booty!!! Follow the clues provided in your registration packet to the treasure chest! The exhibitors are ready and waiting to help you navigate the way. After completing the hunt, drop your map in the treasure chest by **10:00 AM on Friday, April 9, 2010**. Winners will be announced during the break in the exhibit hall at **1:00 PM on Friday, April 9, 2010**! Prizes include free STN memberships, complimentary 2011 conference registrations, overnight hotel stays, sterling silver jewelry, educational materials/products and much more….
Don't get caught hornswaggling or you'll have to walk the plank!!!

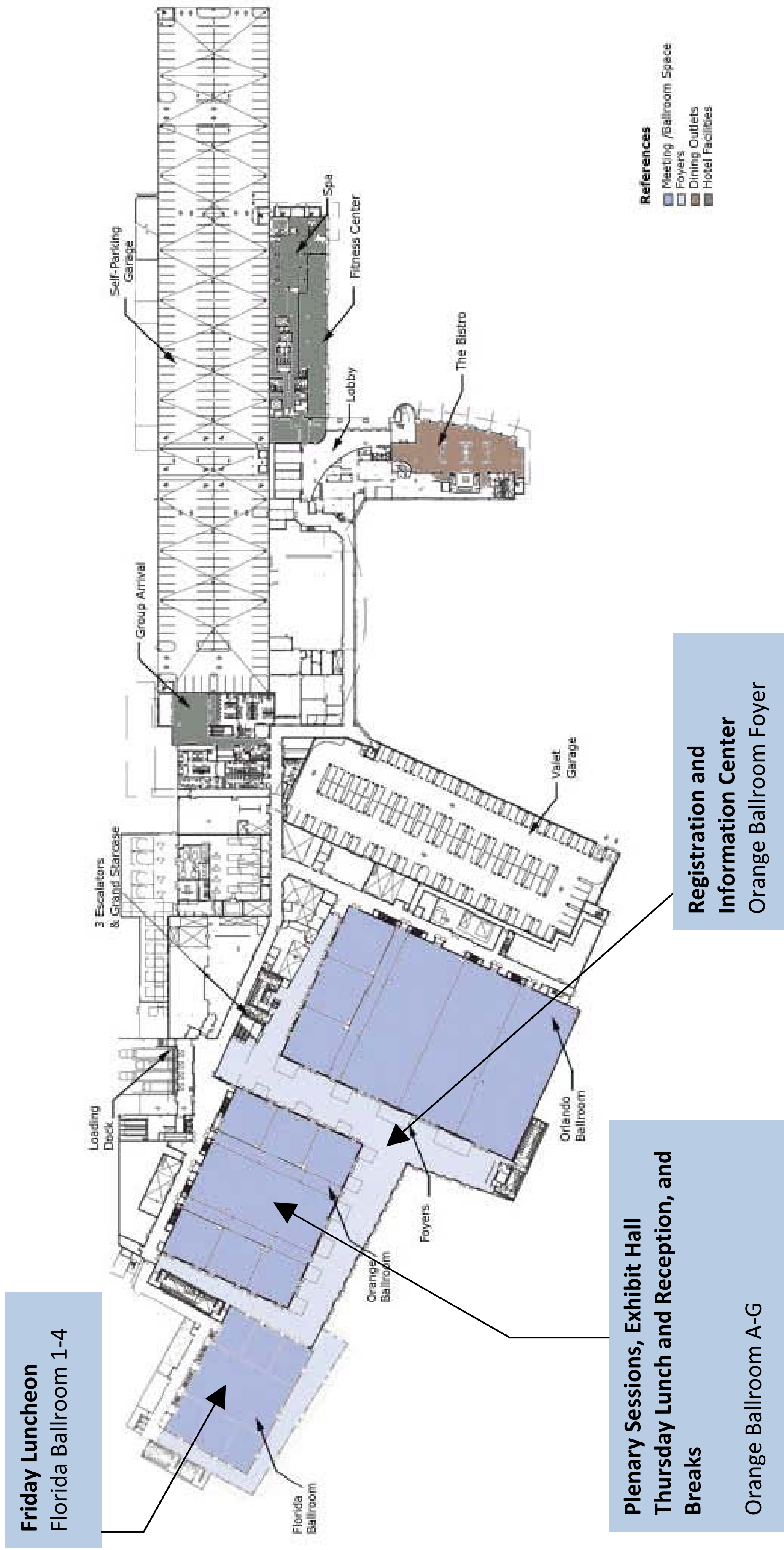
Hotel Floor Plan – Lobby Level



Pre-Conference Sessions,
Concurrent Sessions and
SIG & Committee Meetings

Lake rooms are located on the Lobby Level just past the Marketplace. Follow the signs to the appropriate meeting room for your session.

Hotel Floor Plan – Lower Level



FACULTY (SEE WEDNESDAY, THURSDAY & FRIDAY SECTIONS FOR BIOGRAPHIES)

Mary Aitken, MD, MPH Arkansas Children's Hospital Little Rock, Arkansas	**Alice Gervasini, PhD, RN** Assistant Professor of Nursing Massachusetts General Hospital Boston, Massachusetts	**Frank "Tres" Mitchell, MD, MHA, FACS** Chairperson-Verification Review Committee & Medical Director Trauma and Surgical Critical Care St. John Health System Tulsa, Oklahoma
Holly Bair, RN, MSN, NP Trauma Program Manager William Beaumont Hospital Royal Oak, Michigan	**Mike James** Alabama State CPS Coordinator Alabama Department of Economic and Community Affairs Huntsville, Alabama	**Joe Perno, MD** Assistant Medical Director Emergency Center All Children's Hospital St Petersburg, Florida
Cindy Blank-Reid, RN, MSN, CEN Trauma Clinical Nurse Specialist Temple University Hospital Philadelphia, Pennsylvania	**Donald Jenkins, MD, FACS** President, EAST Senior Associate Consultant Trauma Medical Director Mayo Clinic Rochester, Minnesota	**Pam Pieper, PhD, ARNP, PNP-BC** Clinial Associate Professor College of Nursing University of Florida Jacksonville, Florida
Ernest J. Block, MD, MBA, EMT-P, FACS, FCCM Director, Acute Care Surgery Holmes Regional Medical Center Melbourne, Florida	**Amy Koestner, RN, MSN** Trauma Program Manager Borgess Medical Center Kalamazoo, Michigan	**Susan Rzucidlo, MSN, RN** Pediatric Trauma Program Manager Penn State Hershey Hershey, Pennsylvania
Melanie Brewer, DNSc, RN, FNP-BC Director, Nursing Research Scottsdale Healthcare Scottsdale, Arizona	**Karen Macauley, RN, MEd** Pediatric Trauma Program Director All Children's Hospital St Petersburg, Florida	**Kathryn Schroeter, PhD, RN, CNOR** Editor, Journal of Trauma Nursing Assistant Professor of Nursing Marquette University College of Nursing Milwaukee, Wisconsin
Jonathan B. Cohen, MD, FCCP Florida Gulf-to-Bay Anesthesiology Critical Care Medicine Tampa General Hospital and The University of South Florida Tampa, Florida	**Pat Manion, RN, MS, CCRN, CEN** Trauma Program Manager Genesys Regional Medical Center Grand Blanc, Michigan	**Cristy Thomas, DNP, FNP-BC** Trauma Nurse Practitioner University of Nevada School of Medicine Las Vegas, Nevada
Sue Cox, RN, MS, CPEN, PHN STN President Rady Children's Hospital and Health Center San Diego, California	**Kathleen D. Martin, MSN, RN, CCRN** Trauma Program Nurse Director Landstuhl Regional Medical Center US Army Military Treatment Facility Landstuhl, Germany	**Sydney J. Vail, MD, FACS** Medical Director for Trauma Maricopa Medical Center Phoenix, Arizona
Laura Criddle, PhD, RN, ACNS-BC, CCRN, CCNS, CNRN, CEN, CFRN, CPEN, ONC, NREMT-P, FAEN Clinical Nurse Specialist Laurelwood Consulting Scappoose, Oregon	**Kimberly Meyer, MSN, ACNP-BC, CNRN** Neuroscience Clinician Defense and Veterans Brain Injury Center Walter Reed Army Medical Center Washington, DC	**Michelle Ziglar, MSN, RN** Director Trauma & Aeromedical Services Shands at the University of Florida Gainesville, Florida
Diana Fendya, MSN, RN Pediatric Trauma & Acute Care Nurse Specialist EMS Services for Children Children's National Medical Center Washington, DC	**Judy Mikhail, RN, MSN, MBA** Trauma Administrator Hurley Medical Center Flint, Michigan	
Mary Kate FitzPatrick, RN, MSN, CRNP-BC Clinical Director, Nursing Operations Hospital of University of Pennsylvania Philadelphia, Pennsylvania	***Faculty Disclosure Statement:*** *All faculty participating in continuing education activities sponsored by the Society of Trauma Nurses are required to disclose to the audience any relevant commercial relationships and/or any non-FDA approved use of a drug or a device that is included in the presentation.*	

2010 BOARD OF DIRECTORS

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Judy Mikhail, RN, MSN, MBA
Hurley Medical Center

Heidi A. Hotz, RN
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Mary Kate Fitzpatrick, RN, MSN, CRNP-BC
Hospital of University of Pennsylvania

Connie Mattice, RN-C, MS, CCRN, ANP
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MIEMSS

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Bassett Health Care

The Society of Trauma Nurses (STN) is a membership-based, non-profit organization whose members represent trauma nurses from around the world.

Vision: The Society of Trauma Nurses envisions a health system in which trauma nurses work collaboratively to comprehensively impact trauma care delivery throughout the world.

Mission: The Society of Trauma Nurses is the lead professional nursing organization which promotes the advancement of trauma nursing, trauma education, and the development of nursing leadership at the national and international levels.

The mission of the Society of Trauma Nurses is to assist nations, states and local health authorities with the development and maintenance of trauma systems and trauma centers; to work within the trauma system to ensure all people have access to and receive the highest quality of trauma care. This is accomplished across the trauma continuum of care within an environment that fosters visionary care and interdisciplinary collaboration.

STN MEMBERSHIP BENEFITS INCLUDE:

- A subscription to STN's quarterly publication, the *Journal of Trauma Nursing* (JTN).
- Access to strong trauma educational programs designed specifically for this field including:
    - Advanced Trauma Care for Nurses (ATCN)
    - Trauma Outcomes & Performance Improvement Course (TOPIC)
    - STN's Annual Conference
- The opportunity to participate in Special Interest Groups.
- The opportunity to gain skills by serving in leadership roles at state and regional levels.
- The knowledge that you are a part of an association dedicated to advancement in the field of trauma.

STN is dedicated to the professional growth of its members, now numbering over 1,100. These individuals represent trauma nursing leaders across the continuum of trauma care in the:

- emergency department,
- intensive care units,
- pre-hospital setting,
- perioperative arena,
- rehabilitation and outpatient services,
- surgical floors.

STN is involved in trauma-related activities at the local, regional and international levels, in support of its mission and goals.

SOCIETY OF TRAUMA NURSES MEMBERSHIP APPLICATION

SOCIETY OF TRAUMA NURSES

❑ New Member ❑ Renewal, member #: ______________________

FIRST NAME MIDDLE NAME/INITIAL LAST NAME

PROFESSIONAL CREDENTIAL(S)

JOB TITLE

INSTITUTION (Include department, unit or mail stop where possible)

ADDRESS

CITY STATE/PROVINCE ZIP/POSTAL CODE

COUNTRY

OFFICE PHONE

E-MAIL ADDRESS

❑ Active Member – licensed to practice as a Registered Nurse; voting membership
❑ Associate Member – **not** licensed to practice as a Registered Nurse; non-voting membership

Address where your *Journal of Trauma Nursing* (JTN) subscription should be mailed, if different from your mailing address. Please include department, unit or mail stop where possible.

ADDRESS

CITY STATE/PROVINCE ZIP/POSTAL CODE

COUNTRY

MEMBERSHIP LIST RENTAL EXCLUSION

On occasion, STN rents its membership list, excluding e-mail addresses, to vendors that offer products, services or employment opportunities that STN believes would be of interest to its members. If you do not wish your name to be included on these lists, please check here. ❑ Please exclude me.

MEMBERSHIP DUES

❑ $100 (USA) ❑ $115 (all other countries—US dollars)

Additional contribution to STN (tax-deductible): $ ______________

Total Payment: $ ______________

PAYMENT METHOD

❑ Check (payable to Society of Trauma Nurses)

Check # ______________

Select type of credit card ❑ Visa ❑ Master Card ❑ American Express

CREDIT CARD NUMBER

EXPIRATION DATE (mm/yy) ZIP CODE OF BILLING ADDRESS

CARDHOLDER'S SIGNATURE CARDH0LDER'S NAME (if diffferent than applicant)

SUBMIT TO: Society of Trauma Nurses | 1020 Monarch St, Suite 300B | Lexington, KY 40513
P: (859) 977-7456 | F: (859) 977-7441 | www.traumanurses.org | sclements@traumanurses.org

MEMBERSHIP SURVEY

Please specify one option that best decribes your primary role:

- ❑ Academic/Educator
- ❑ Administrator
- ❑ Advanced Practice Nurse
- ❑ Clinical Nurse
- ❑ Clinical Nurse Specialist / Hospital Educator
- ❑ ICU / ED / OR Nurse
- ❑ Injury Prevention Coordinator
- ❑ Research Nurse
- ❑ Trauma Coordinator
- ❑ Trauma Program Manager
- ❑ Trauma Registrar

SPECIAL INTEREST GROUPS

Please indicate any Special Interest Group(s) in which you are interested:

- ❑ Advanced Practice Nursing
- ❑ Injury Prevention
- ❑ Neurotrauma
- ❑ Pediatric Trauma
- ❑ Rural Trauma

SUGGESTIONS

Please provide suggestions for programs or activities for STN to consider.

Referred by

U.S. Members, please note: A portion of membership dues may be tax deductible as an ordinary and necessary business expense. Dues are not deductible as a charitable contribution for federal income tax purposes. Approximately $30 of annual membership dues is applied to a one-year subscription to the *Journal of Trauma Nursing*. Consult your tax advisor. STN is a 501(c)(3) organization; FEIN #52-1780525.

THE STN MEMBERSHIP YEAR IS BASED UPON JOIN DATE

Invoices are issued to the address on file with STN. Be sure to advise STN of any changes to keep your record current.

7:45 AM – 4:30 PM Trauma Outcomes and Performance Improvement Course (TOPIC)

Lake Down

Moderator – Connie Mattice, RN, MSN, CCRN, ANP

TOPIC was developed by a seasoned group of trauma leaders, to assist participants with the Performance Improvement (PI) process in trauma care. This one-day course focuses on skill development for trauma program staff who are involved in the ongoing evaluation of trauma care across the continuum. It offers concrete strategies for the monitoring of trauma care, loop closure, and patient outcomes. The course provides practical lessons for all levels of trauma centers, from entry level to those who have achieved a mature phase of program development. TOPIC consists of 12 modules in PI and outcomes assessment, and includes over 50 case study examples, sample documents, and templates.

Kate FitzPatrick, RN, MSN, CRNP-BC
Hospital of the University of Pennsylvania - Philadelphia, Pennsylvania

Kate FitzPatrick is a past President of the Society of Trauma Nurses (2004) and served o n the STN board for 6 years. She continues to serve on the editorial review board for the Journal of Trauma Nursing. She also served three terms on the Board of the Pennsylvania Trauma Systems Foundation. She is currently on the Board of Trustees (Secretary) for the Eastern Association for the Surgery 0f Trauma. She is member of the Pennsylvania State Nurses Association.

Kate has over 23 years of nursing experience involving expertise in the areas of nursing operations, quality/safety, patient flow, rapid response, trauma system development, trauma center development/accreditation and trauma performance improvement. Her clinical background includes pre-hospital, emergency/trauma, and surgical nursing. In addition, she served as the State Trauma System Coordinator for the Division of Public Health in Delaware, which included responsibility for chairing the statewide trauma system development initiative. Kate has held hospital-based leadership positions as the Trauma Performance Improvement Coordinator, Trauma Program Manager, and Trauma Clinical Programs Administrator at the Hospital of the University of Pennsylvania in Philadelphia, a regional resource Level I Trauma Center. Currently, she is Nursing Clinical Director with responsibility for Quality, Safety, and the Unit Based Clinical Leadership model at the Hospital of the University of Pennsylvania.

Kathleen D. Martin, MSN, RN, CCRN
Landstuhl Regional Medical Center - US Army Military Treatment Facility, Landstuhl, Germany

Kathleen Martin has over 30 years of experience in trauma care delivery. She is currently the Trauma Program Nurse Director at Landstuhl Regional Medical Center in Germany. Her career has spanned diverse nursing positions including staff RN in the trauma ICU, clinical nurse specialist, trauma program manager, consultant, trauma nurse site surveyor, and entrepreneur in her own consulting company. She has authored many research papers and book chapters, and her research interests include hypothermia in trauma, organ donation, trauma performance improvement (PI), the use of nurse practitioners in trauma care, and trauma systems. She is an active educator, teaching ATCN and the Trauma Outcomes and Performance Improvement Course (TOPIC), and has had numerous invited speaking engagements. She was the recipient of the Society of Trauma Nurses' (STN's) 2009 Distinguished Lectureship Award.

Kathleen has served on the STN board of directors in various positions for 16 years and is a past president of STN. Her involvement with the STN has been as an original author/ faculty of the TOPIC and TOPIC-M course, Editor in Chief of the Journal of Trauma Nursing, international faculty for the ATCN Course, and as a member of the collaborative STN and American College of Surgeons (ACS) PI committee charged to develop a verification readiness course. She is a current member of the STN board of directors as the TOPIC Committee Chair.

TOPIC manuals will be distributed at the start of the session.

8:00 AM – 4:00PM Optimal Trauma Center Management and Organization Course

Lake George

Moderator – Amy Koestner, MSN, RN

The American College of Surgeons Committee on Trauma (ACS COT) and the Society of Trauma Nurses (STN) have partnered to develop the ***Optimal Trauma Center Organization & Management Course.***

- Both physicians and nurses teach this collaborative course. Its goal is to enhance trauma center performance and to improve patient care through implementation of the ACS COT Trauma Center Standards.
- Whether yours is a mature verified center or a hospital preparing for designation, this course is designed to help participants develop strategies, processes, and operations to support trauma systems based on their own unique environments. It is designed to help you take your trauma center to the next level, beyond verification or designation.
- The nuances of implementing or improving upon trauma center criteria within the structure of your specific facility will be reviewed in an interactive forum.

The course is designed to assist Trauma Medical Directors, Trauma Program Managers/Coordinators, Administrators, Trauma Registrars, State/Region personnel and other disciplines involved in trauma.

Frank “Tres” Mitchell, III, MD, MHA, FACS

St. John Health System, Tulsa, Oklahoma

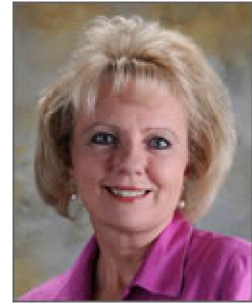
Dr. Frank “Tres” Mitchell has a long history in the trauma community and is highly visible on the national stage. He has been a member and officer of the National ATLS Committee, a member of the Verification Review Committee of the ACS Committee on Trauma, Region Chief for the Committee on Trauma, and Chairman of the Oklahoma State Committee on Trauma. Dr. Mitchell has been a Verification Review Committee Site Reviewer since 1999 and is the Current Chair of the Committee on Trauma Verification Review Committee. Dr. Mitchell was a site surveyor for the first Trauma Verification Review Committee Site Visit outside the U.S. at Landstuhl Regional Medical Center, Germany. In his role as Chair of the Verification Review Committee, Dr. Mitchell has fostered a collaborative relationship with the Society of Trauma Nurses (STN), which has included support for the new “OPTIMAL” course as well as lecturing at our annual conference for the past three years.

He is the Medical Director, Trauma and Surgical Critical Care at St. John Medical Center in Tulsa, Oklahoma. He has been a general surgeon, trauma surgeon, and director of both trauma and critical care in both Oklahoma and Kansas. Dr. Mitchell graduated with a BA from the University of Missouri, earned his MD from Tulane in New Orleans. He completed his General Surgery Residency at Parkland Memorial in Dallas. He is board certified in General Surgery and in Surgical Critical Care. Dr. Mitchell is a frequent speaker at regional and national conferences. He was also the Course Director for the annual Adult and Pediatric Trauma Symposium for multiple years.

Dr. Mitchell is active in many professional organizations, including the American Society for Bariatric Surgery, the Parkland Surgical Society, the Tulane Surgical Society, and the American Association for Surgery of Trauma, the Society of Critical Care Medicine, Western Trauma Association, and the Society of Law, Medicine & Ethics.

Judy Mikhail, RN, MSN, MBA

Hurley Medical Center, Flint, Michigan



Judy Mikhail has over 30 years of progressive trauma nursing experience, most recently as the administrator for Trauma, Bariatrics, and Neuroservices at Hurley Medical Center, a Level-1 Trauma in Flint, Michigan. She began her nursing career in the Burn Unit at Hurley, and progressed from surgical ICU staff nurse to clinical nurse specialist and ultimately a trauma program manager and trauma administrator. Judy earned her diploma in nursing from Hurley Medical Center School of Nursing, her BSN from the University of Michigan, and MSN from the University of Texas. In 2003, she completed work on her MBA from Colorado State University. Judy is currently a full-time doctoral nursing student at the Medical University of South Carolina. She has been active in many professional organizations, including the Eastern Association for the Surgery of Trauma (EAST), the American Burn Association (ABA), the American Organization of Nurse Executives (AONE), the Emergency Nurses Association (ENA), the American Association of Critical Care Nurses (AACN), and the Society of Trauma Nurses (STN)

Judy is a nationally recognized speaker in trauma care and an active educator and course director for PreHospital Trauma Life Support (PHTLS), Advanced Trauma Life Support (ATLS), Advanced Trauma Care for Nurses (ATCN), the Trauma Nurse Core Course (TNCC), the Course in Advanced Trauma Nursing (CATN), Fundamental Critical Care Support (FCCS), and Advanced Cardiac Life Support (ACLS). She serves as an adjunct instructor for the University of Michigan-Flint, School of Nursing. Judy has authored over 18 publications in trauma, including the evaluation and treatment of abdominal trauma, the use of midlevel providers in trauma centers, injury severity scoring, resuscitation endpoints in trauma, and care of the burn patient. She has won three local research awards. She has served as President and Treasurer of the board of directors of STN. Judy has been involved in trauma system development in Michigan, including serving as President of the Michigan Trauma Coalition, and she currently serves on the State of Michigan Trauma Advisory Committee.

Amy Koestner, MSN, RN

Borgess Medical Center, Kalamazoo, Michigan

Amy Koestner is the Trauma Program Manager at Borgess Medical Center, a level 1 Trauma Center in Kalamazoo, Michigan. Amy has a 30-year nursing career, with experience spanning the bedside in pediatric ICU, regional pediatric education, flight nursing, adult ICU bedside care, and the past 15 years in the role of trauma program manager. She has led multiple trauma centers through five ACS verification visits. Amy earned her BSN from Nazareth College, and her MSN from Wayne State University.

Amy has been active in the Society of Trauma Nurses (STN) for over 10 years, serving in a variety of leadership roles, including past president in 2008. Her involvement in STN has included participation as an original author/ faculty member for the Optimal Trauma Center Organization & Management Course, as one of the key authors of the Senior Lifestyle & Injury Prevention (SLIP) course, as national & international faculty for the Advanced Trauma Care for Nurses (ATCN) course, and most recently as the appointed STN chair liaison to the Committee on Trauma. Amy remains active as faculty for ATCN, the Trauma Nurse Core Course (TNCC), the Emergency Nursing Pediatric Course (ENPC), and speaks on trauma topics on a state and national level.

Amy has been involved in trauma system development in Michigan through her leadership role in the Michigan Trauma Coalition and Regional Trauma Advisory Committee in Southwest Michigan.

Manuals and supporting materials for the Optimal course will be distributed at the start of the session.

12:20 PM – 4:35PM Getting Started: A Primer on Trauma Research & Evidence-Based Practice

Lake Hart

Moderator – Pat Manion, RN, MS, CCRN, CEN
Course Director – Kathryn Schroeter, PhD, RN, CNOR

Trauma centers and hospitals seeking magnet status are expected to conduct trauma research and integrate evidence-based standards into their practice. But not all trauma program staff feel they are prepared for the challenge. This dynamic half-day course will provide a great introduction – or a review – for the trauma professional whose work includes research or publication.

This 4-hour pre-conference is designed to provide nurses and other health care professionals with the basic knowledge and tools necessary to participate in the design and implementation of trauma research projects and evidence-based practice (EBP) projects. Each participant is asked to bring one idea for a research or EBP project: During the small group breakout session, faculty will help each participant develop that idea. The course includes:

- Overview of Study Designs
- Research Projects That Come From Your Trauma Registry
- Primer on Evidence-Based Practice
- Small Group Sessions: Developing Your Research or EBP Idea
- Some Simple Statistics and Terms
- Conducting a Literature Search
- Elements of a Good Abstract

Whether you are a new to research and feeling intimidated, or if you are someone who just needs a little refresher, this course can help you navigate your way to a successful project.

Kathryn Schroeter, PhD, RN, CNOR

Editor, Journal of Trauma Nursing & Marquette University College of Nursing, Milwaukee, Wisconsin

Kathryn Schroeter is Editor of the Journal of Trauma Nursing (JTN). She is an Assistant Professor in the College of Nursing at Marquette University where she currently teaches research methods at the graduate and undergraduate levels. She holds the position of adjunct Assistant Professor of Bioethics at the Medical College of Wisconsin. She serves as a Magnet Accreditation Appraiser for the American Nurses Credentialing Center (ANCC), and continues to work as an Education Coordinator at Froedtert Hospital – a Level-I trauma center – also in Milwaukee.

Kathryn received her BSN degree from Alverno College in Milwaukee, and her MA in Bioethics from the Medical College of Wisconsin. She received her MS degree from the school of Education at the University of Wisconsin - Milwaukee (UWM) and her PhD from the University of Wisconsin-Milwaukee. She has many years of experience in the operating room/perioperative nursing as an educator, manager, consultant, and editor.

Kathryn has written and presented extensively on bioethics topics. Her membership in professional organizations include: the Association of Perioperative Registered Nurses (AORN), the American Nurses' Association (ANA), the American Society for Bioethics and the Humanities (ASBH) and the Eta Nu chapter of Sigma Theta Tau. Kathryn serves on the board of the Wisconsin Nurses' Association (WNA), the Competency and Credentialing Institute (CCI) where she has been active on the CCI Research Committee as both a member and chairperson. She is a member of the American Board of Nursing Specialties (ABNS) Research Committee. She has also chaired the AORN national research committee.

Holly Bair, RN, MSN, NP

William Beaumont Hospital, Royal Oak, Michigan

Holly Bair is the Trauma Program Manager at William Beaumont Medical Center in Royal Oak, Michigan. She is a licensed Nurse Practitioner in the state of Michigan and received her Masters Degree from Madonna University in 2001. In 1995 Holly came to Beaumont Hospital to create a Level I Trauma Center. Beaumont Hospital - Royal Oak has successfully re-verified six times under her direction. Along with her duties on the Trauma Service she has also accepted responsibility as the Director of the Beaumont Access Center. Holly has multiple publications, including papers reflecting her work on a rapid reversal protocol for anticoagulated patients with traumatic head bleeds. She has lectured at the state, regional, and national level on a range of trauma related subjects. She belongs to many profession organizations and is currently the Secretary of the Michigan Emergency Nurses Association.

Melanie Brewer, DNSc, RN, FNP-BC

Scottsdale Healthcare, Scottsdale, Arizona

Dr. Melanie Brewer is the Director of Nursing Research at Scottsdale Healthcare and is a Clinical Associate Professor in the College of Nursing at Arizona State University. Her research interests include healthcare informatics, evidence-based practice, and the psychosocial and physiological outcomes of health care. She received her BSN from the University of New Mexico and her MSN from Arizona State University in Community Health Nursing, where she also completed the Family Nurse Practitioner program. She went on to complete her Doctor of Nursing Science at Johns Hopkins University School of Nursing in Baltimore, Maryland in 2004.

Dr. Brewer has been the recipient of several awards, including the Health Care Professional of the Year award from the West Texas Parkinsonism Society in 1991, and the Achievement Reward for College Scientists Foundation Scholar in 1997-98. In 2006, while on staff at Phoenix Children's Hospital as the Director of Clinical Outcomes and Nursing Research, Dr. Brewer received their Excellence in Leadership and Mentorship/ Nursing Excellence Award. She has had a diverse career as a nurse manager, research nurse clinician, neurology clinical coordinator, nurse practitioner, research project coordinator, consultant, associate professor, and nursing research director.

Dr. Brewer is active in many professional organizations and is a current board member of Sigma Theta Tau – Beta Upsilon Chapter. She is a member and data reviewer for the Arizona Diabetes Collaborative/ Partners in Quality, and a faculty consultant for the Student Nurses Association of Arizona. She is widely published and has mentored many students working on their research and evidence-based practice projects. She frequently lectures on the evaluation of outcomes and the implementation of evidence-based practice.

Alice Gervasini, PhD, RN

Massachusetts General Hospital, Boston, Massachusetts

Dr. Alice Gervasini is the Director of Trauma and Emergency Surgery at Massachusetts General Hospital and a surgery instructor at Harvard Medical School. She received her diploma in nursing from the New England Deaconess Hospital in Boston, Massachusetts and her BSN from the American University in Washington, DC. She continued her education with a Masters of Science at the University of Maryland at Baltimore in Trauma/Critical Care Nursing and then received a PhD in Nursing from the Boston College School of Nursing in Boston, Massachusetts. She is an active manager, educator, and researcher, and is a frequent lecturer on a variety of trauma and critical care topics, including family presence during resuscitation, care of the obese trauma patient, vascular trauma, quality indicators for trauma and critical care, pre-hospital trauma management, and trauma systems development. Dr. Gervasini has been the principal and co-investigator on many funded research projects, and has published extensively, including co-authoring a chapter in the Handbook of Clinical Trauma Care: The First Hour (4th Edition, 2006, Mosby-Elsevier). She is also a member of the Editorial Review Board of the Journal of Trauma Nursing.

Pat Manion, RN, MS, CCRN, CEN

Grand Blanc, Michigan

Pat Manion has over 13 years of experience in trauma program management, most recently as the trauma program director at Genesys Regional Medical Center in Grand Blanc, Michigan. She has worked in critical care and trauma education, orthopedic case management, cardiac surgery program development, direct patient care in critical care and trauma, and trauma program development. Pat has been very active in the Society of Trauma Nurses (STN) for the past 10 years, and is currently the Secretary on the STN Board of Directors. She also served as the STN Conference Chairperson from 2006 through 2009. She is very active in the Emergency Nurses Association, serving as State officer and State Faculty for TNCC. Pat has spoken extensively in the State of Michigan and nationally on critical care and trauma topics. She has many publications to her name, and has been a subject matter reviewer/ editor for Principles of Basic Trauma Nursing (2nd Edition, 2006, Western Schools, Inc.) and the Trauma Nursing Core Curriculum (TNCC) textbook (6th Edition revision, 2007). Her areas of particular expertise are geriatric trauma, complications of trauma, trauma case studies, and injury prevention for the elderly population. She has mentored many other prospective trauma centers as they worked toward successful ACS trauma center verification.

Materials for the Primer course will be distributed at the start of the session.

WEDNESDAY, APRIL 7 – PRE-CONFERENCE SESSIONS

12:30 PM – 4:35PM Discover the World of Pediatric Trauma

Lake Monroe

Research Panel – Moderator: Sally Snow, BSN, RN, FAEN
Injury Prevention Panel – Moderator: Lynn Schweer, RN, MSN, CNP

For those who care for injured children, the timely dissemination of pediatric trauma research and up to date injury prevention strategies rank among the highest priorities. Unintentional injury remains the leading cause of death in children after age 1, and members of STN's Pediatric Special Interest Group (SIG) have led the way in promoting research, prevention, and education for this special population. Their latest initiative is this superb half-day course, **DISCOVER THE WORLD OF PEDIATRIC TRAUMA**.

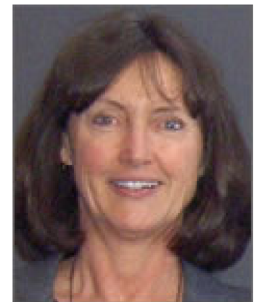
Join top pediatric leaders at this course, as they share their cutting-edge knowledge on the following topics:

- Health-Related Quality of Life after Mild Traumatic Brain in Children
- Knowing When to Send Them: Pediatric Inter-Facility Transfer Agreements and the EMSC Study
- Post-Traumatic Stress – Resiliency after the Unthinkable
- Kids driving ATV's: Toward a Higher Safety Standard
- Are Airbags a Risk to Children?
- America's Unsafe Streets: Bike & Pedestrian Safety
- Who's in the Water? Water Safety and Water, Water, Everywhere

This half-day program is intended for anyone who cares for injured children. Don't miss this once-a-year opportunity to connect with your colleagues in pediatric trauma.

Pam Pieper, PhD, ARNP, PNP-BC

University of Florida, Jacksonville, Florida



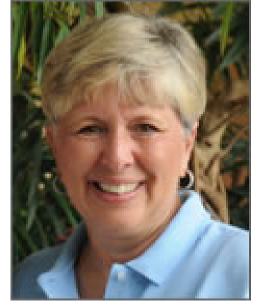
Dr. Pam Pieper has worked as an advanced practice nurse with the Division of Pediatric Surgery, University of Florida Jacksonville campus since 1984. From 1990-2003, she was the Trauma Nurse Coordinator at the Level I Trauma Center there, first for the pediatric trauma program and, subsequently for the entire program. She is a frequent speaker and has been responsible for numerous teaching programs involving nursing care of both surgical neonates and critically injured children. She is recognized as a national leader in quality monitoring and outcomes assessment of pediatric trauma care.

Dr. Pieper received her BA in Biology from Franklin and Marshall College, her BSN from Cornell University - New York Hospital School of Nursing, and her MSN from the University of Alabama in Birmingham, as a pediatric clinical nurse specialist with a focus on infants. She went on to complete her pediatric nurse practitioner training at the University of Florida in 1991 and her PhD from Barry University in 2009.

Since 2006, Dr. Pieper has been a consultant to the Florida Department of Health Office of Trauma for pediatric trauma nursing and the state trauma registry. She has been a member of the Florida Emergency Medical Services for Children Advisory Committee since her appointment in 2007. Her dissertation topic was on health-related quality of life in children who sustained a mild traumatic brain injury, at 1-month post-injury, from the perspectives of the children and their proxies. The data she will be presenting at the Society of Trauma Nurses (STN) meeting is from an IRB-approved continuation of that study.

Diana Fendya, MSN, RN

Children's National Medical Center, Washington, DC



Diana Fendya is an advanced practice pediatric Nurse and Trauma/Acute Care Specialist. She has served as the manager of a state designated Level I pediatric trauma program in St. Louis for 14 years, where she also managed and provided leadership for four state EMSC grants. She presently works as the Trauma/Acute Care Specialist for the Emergency Medical Services for Children (EMSC) National Resource Center (NRC), based at Children's National Medical Center in Washington, DC. The NRC provides technical assistance to state grantees as they strive to improve the delivery of emergency care of children and to the Federal Program based at the Health Resources Services Administration. Diana earned both her BSN and MSN (Nursing of Children and Families) from St. Louis University School of Nursing. She has spoken at many local and national meetings on pediatric trauma care and injury prevention topics. She has also authored numerous manuscripts on pediatric trauma and emergency care in peer-reviewed literature. Diana co-authored the chapter "Preparing Nurses to Plan and Care for Children During Disaster Situations," in the textbook, Preparing Nurses for Disasters Management (Langan JC and Dotti C. James DC, Editors, 2005).

Mary Aitken, MD, MPH

Arkansas Children's Hospital, Little Rock, Arkansas

Dr. Mary Aitken is a general pediatrician practicing at Arkansas Children's Hospital (ACH) who is also a researcher. She is a Professor of Pediatrics University of Arkansas for Medical Sciences (UAMS), Section Chief of the Center for Applied Research and Evaluation in the Department of Pediatrics at UAMS, and the Medical Director of the ACH Injury Prevention Center. Dr. Aitken participates in resident and student education in the outpatient and inpatient setting. She is also involved in education of public health students as part of the Maternal and Child Health Division of the UAMS College of Public Health. Dr. Aitken serves on the Executive Committee for the Section on Injury, Poison, and Violence Prevention for the American Academy of Pediatrics. Her research interests include prevention of motor vehicle and all-terrain vehicle injury, as well as how to improve the quality of life of children after injury, particularly traumatic brain injury. She has received funding for her projects from the Emergency Medical Services for Children Program of MCHB and other agencies. She was the 2000 recipient of the American Congress of Rehabilitation Medicine's Sidney and Elizabeth Licht Award for Excellence in Scientific Writing. She also received a Robert Wood Johnson Generalist Physician Scholar award to advance her research program in evaluating health-related quality of life for injured children.

Dr. Aitken attended the University of North Carolina School of Medicine and completed a pediatrics residency at Johns Hopkins Hospital in Baltimore, Maryland. She also received a Master's in Public Health degree with a concentration in epidemiology during a General Academic Pediatrics fellowship at the University of Washington.

Mike James

Alabama State Child Passenger Safety Coordinator and Alabama Department of Economic and Community Affairs
Huntsville, Alabama

Mike James is the coordinator and lead instructor for child passenger safety (CPS) for the State of Alabama. He is also a board member of the National Child Passenger Safety Board. Mike has worked on CPS issues since 1997, and has been certified since 1998. He has taught classes in Nebraska, Mississippi, Florida, Tennessee, Louisiana, New York, Vermont, Alabama and Georgia. In his role as Alabama's State CPS Coordinator, Mike is responsible for the coordination of efforts to get communities trained in CPS, and has personally been involved in the education of thousands of parents on the proper use of their car seats. He has also developed a curriculum for the safe transportation of children with special needs that is designed specifically for parents, occupational therapists, and physical therapists. In addition, he has assisted vehicle manufacturers in the development of programs to safely transport children in their vehicles, help them ensure that their vehicles are child restraint friendly, correct restraint-to-vehicle incompatibilities, and familiarize their vehicle dealerships with child passenger safety. Mike is often consulted on court cases where proper restraint use could have prevented or minimized the injury to the child.

Mike has trained CPS technicians using the CPS renewal curriculum, the NHTSA school bus curriculum, and the standardized CPS curriculum. He is one of the original reviewers of the LATCH/tether manual (SAFE Ride News publications), the standardized curriculum and has been a speaker at many of the National CPS conferences and SAFE Kids Worldwide conferences since 1998.

Susan Rzucidlo, MSN, RN

Penn State Hershey, Hershey, Pennsylvania

For the past 15 years, Susan Rzucidlo has been the pediatric trauma and injury prevention program manager at the level 1 pediatric trauma program at Penn State Hershey Children's Hospital, Milton S. Hershey Medical Center. She is responsible for the administrative and clinical oversight for trauma designation. Susan is the coordinator of Safe Kids Dauphin County and manages the staff and resources for the campus injury prevention initiatives. She is a certified child passenger safety instructor, STN pediatric committee member and Think First chapter coordinator.

Susan received a Bachelor of Science in Nursing from the University of Pittsburgh. She completed a Master's of Science in Nursing from Duquesne University in Education and Trauma / Critical Care nursing. She has many years of experience both as a staff nurse in the pediatric ICU and in staff education as a staff development instructor, education coordinator, and program manager in training and development. She has co-authored multiple papers and her research interests include parental knowledge about infant car seats, child abuse, pediatric blunt pancreatic injury, traumatic stress symptoms, pediatric trauma in the Amish community, and preventing head injuries in children. She is a frequent speaker at local, regional, and national meetings.

Joe Perno, MD

All Children's Hospital, St Petersburg, Florida

Dr. Perno is a Pediatric Emergency Medicine attending and Assistant Medical Director at the All Children's Hospital Emergency Center in St. Petersburg, Florida. He is a frequent lecturer on topics related to childhood injury, including pediatric head injury, poisoning, intentional drug ingestion in adolescents, shaken baby syndrome, pediatric sports injuries, injuries from lightning strike, and mass casualty. Dr. Perno has authored several papers, and his research interests include parental satisfaction and expectations in the Emergency Department, histamine reactions in children receiving radiographic contrast agents, and delayed diagnosis of pediatric injuries. He received his medical degree from St. George's University School of Medicine, and did his pediatric residency at Robert Wood Johnson University Hospital in New Brunswick, New Jersey. Dr. Perno went on to complete a pediatric emergency medicine fellowship at the Primary Children's Medical Center in Salt Lake City, Utah. He is board certified in both pediatrics and pediatric emergency medicine. Dr. Perno was the recipient of two Resident Teaching Awards while at the Robert Wood Johnson University Hospital.

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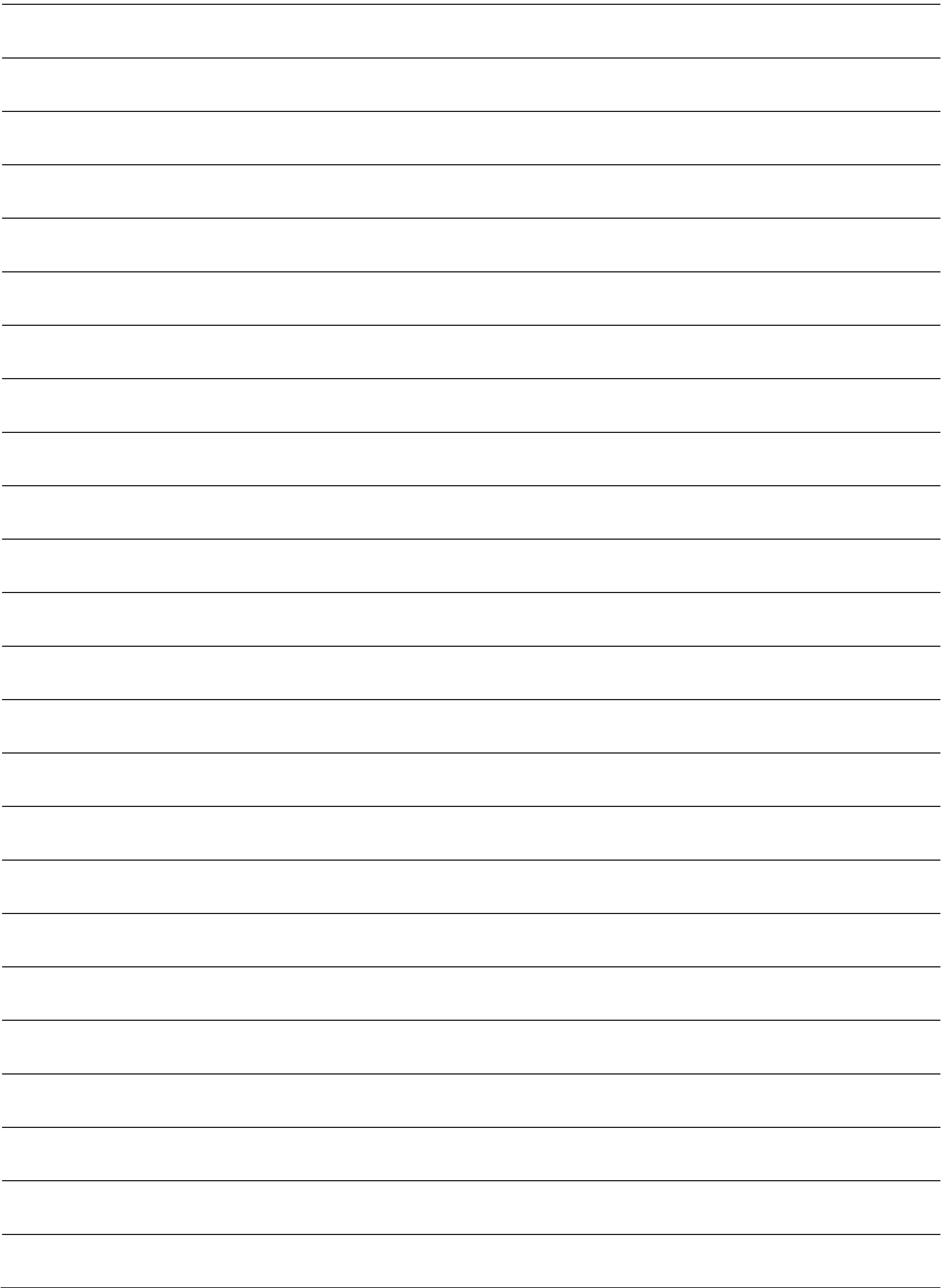

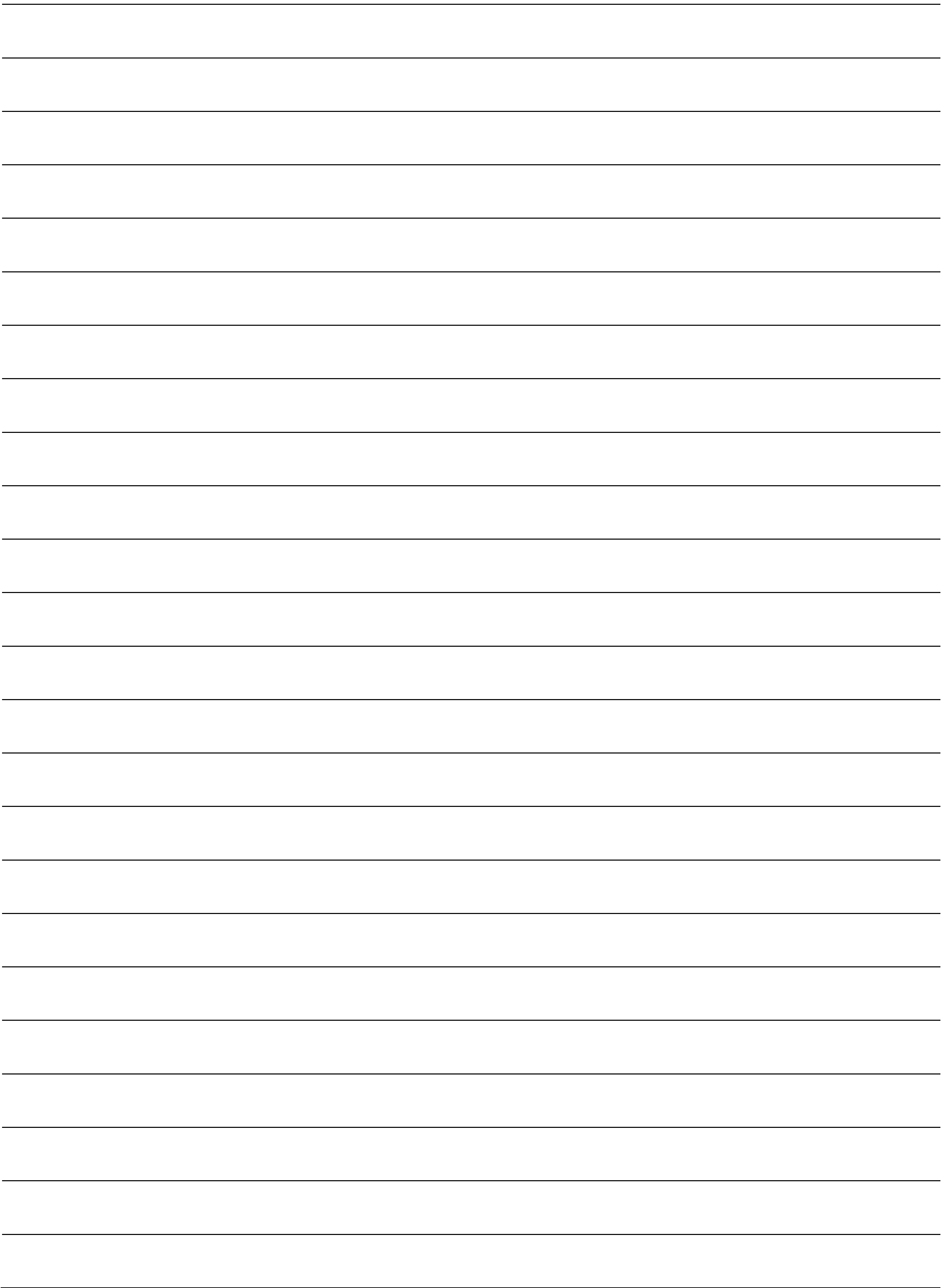

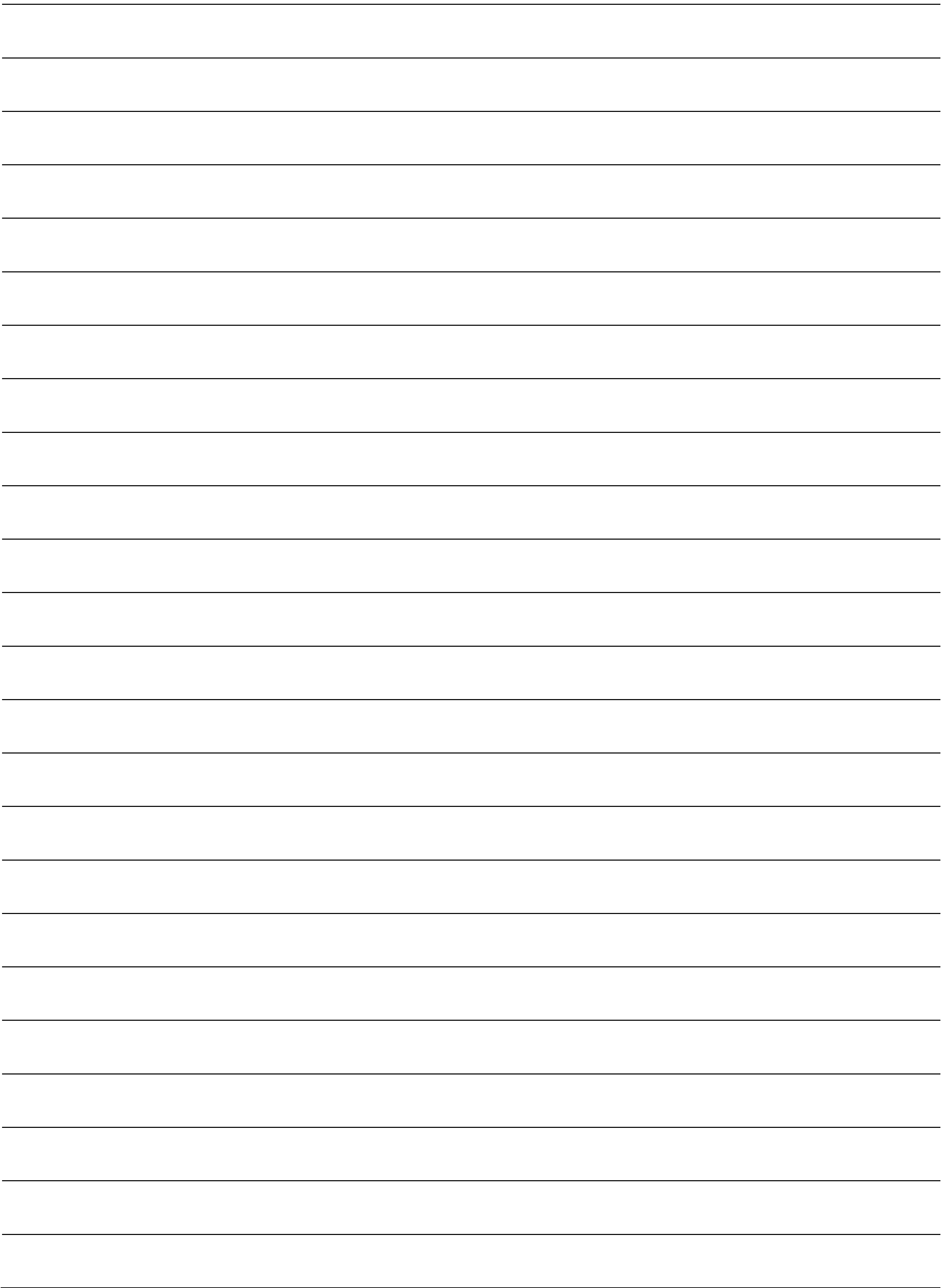

12:30 PM – 4:35PM Managing the Neurotrauma Patient – From Advanced Practice to Outcomes

Lake Concord

Moderators – Linda Reinhart, RN, MSN, CNS, CCRN and Yvonne Michaud, RN, MSN

Traumatic brain injury (TBI) confronts trauma nurses with some of their most challenging patients. Neurotrauma patients require complex assessment and interventions, whether their mechanism of injury is high energy - like blast or gunshot, or low energy – like a fall. As a result of improved care, nearly 5.3 million Americans now survive TBI, and many live with disabilities.

In response to this challenge, STN's Neurotrauma and Advanced Practice Special Interest Groups (SIG's) bring you this half-day pre-conference. When you set sail here, you'll discover the latest information on best practices and outcomes from four experts in neuroscience and advanced practice. Topics include:

- Outcomes Following Geriatric Neurotrauma
- Scope of Practice/Standards for APN's in Trauma/ Neuroscience
- Re-Integration of TBI Patients into the Community
- Rapid Fire panel:
    - Hyponatremia and Falls in the Elderly
    - Mild TBI - Don't Miss the Soft Signs
    - Non-Neurosurgeons & Mid-Level Providers Doing Neurosurgical Procedures
    - Visual Disturbances Following TBI

If you care for TBI patients at any phase of their care, this course will enhance your practice with both its insightful overview and its practical advice.

Laura Criddle, PhD, RN, ACNS-BC, CCRN, CCNS, CNRN, CEN, CFRN, CPEN, ONC, NREMT-P, FAEN

Laurelwood Consulting, Scappoose, Oregon

Dr. Laura Criddle is a clinical nurse at Oregon Health & Science University, Portland Oregon and a clinical nurse specialist at the Laurelwood Group, Scappoose Oregon. She attended nursing school in a quiet suburban community and went from there to a huge medical center in Harlem, where a fascination with the critically ill and injured patient began. This led her to practice in trauma centers from coast-to-coast, and to a career as a clinical nurse specialist in emergency and trauma care. She has held many leadership positions in nursing, including the editorial board of the Journal of Emergency Nursing and a member of the Certified Emergency Nurse (CEN) exam construction and review committee. She has also served as past president of the Oregon Emergency Nurses Association and is the 2010 Chair of the Academy of Emergency Nursing. Dr. Criddle earned her masters degree from the University of California, San Francisco in 1990 and returned to graduate studies to complete a PhD in nursing from Oregon Health & Science University in Portland in 2008. Her areas of primary interest include emergency, trauma, neuroscience, transport, geriatric injury, and critical care. She brings her wide experience in settings from critical care float pool to flight nurse, along with a tremendous breadth of knowledge, to any talk she gives. She has published extensively, including over 60 professional manuscripts, and is the co-editor of the 6th edition of Sheehy's Manual of Emergency Care.

Cristy Thomas, DNP, FNP-BC
University of Nevada School of Medicine, Las Vegas, Nevada

Dr. Cristy Thomas is a Trauma Nurse Practitioner in the Department of Surgery at the University of Nevada School of Medicine, where she manages critically injured trauma patients in Nevada's only Level-I trauma center. She began her career in Traverse City, Michigan, where she completed her Associates Degree in Nursing in 1997 and worked in the ICU at Munson Medical Center. She went on to complete a BSN from the University of Michigan in 2000, and an MSN from the University of Nevada-Las Vegas as a Family Nurse Practitioner in 2003. She has worked as an NP in a variety of settings including family nurse practitioner in dermatology and most recently in trauma critical care. She also has an MBA from Baker College in Flint, Michigan. In 2009, she completed her Doctor of Nursing Practice from Case Western Reserve University.

She has an active teaching role with residents, medical students, nurses, and advanced practice nursing students. She participates in several ongoing research projects. Her research interests include traumatic brain injury, burn care, and the emerging role of the advance practice nurse in the academic acute care trauma setting.

Cynthia Blank-Reid, RN, MSN, CEN
Temple University Hospital, Philadelphia, Pennsylvania

Cynthia Blank-Reid has been a nurse for over 25 years and is currently a Trauma Clinical Nurse Specialist at Temple University Hospital in Philadelphia. She received her undergraduate nursing degree from Villanova University and Master's Degree in Burn, Emergency and Trauma Nursing with a minor in neurosurgery from Widener University. She spent over 16 years at The Hospital of the Medical College of Pennsylvania (MCP) working in general surgery, neurosurgery, and the emergency department. She has worn many hats at their award-winning Level I trauma center, including trauma program coordinator and education and outreach coordinator. When MCP closed, Cindy moved to Temple University Hospital in Philadelphia, where she has been for the past 5 years. She has lectured locally and nationally on a multitude of nursing topics, and has published extensively. She is active in a variety of nursing organizations, including the Emergency Nurses Association (ENA), the American Association of Critical Care Nurses (AACN), Sigma Theta Tau (STT), the American Association of Neuroscience Nurses (AANN), and the Society of Trauma Nurses (STN). She has served as national president of AANN and is currently the chair of the STN Educational Committee.

Kimberly Meyer, MSN, ACNP-BC, CNRN
Defense and Veterans Brain Injury Center, Walter Reed Army Medical Center, Washington, DC

Kim Meyer is a Neuroscience Clinician and traumatic brain injury (TBI) specialist with the Defense and Veterans Brain Injury Center, Washington DC. She has over fifteen years of experience with traumatic brain injury management. After earning her BSN from the University of Louisville, she began her career as a staff nurse in a trauma step-down unit, then on to the surgical ICU. Kim subsequently went on to complete her MSN and Acute Care Nurse Practitioner training in 2001 from the University of Kentucky. Kim has worked as a clinical research coordinator and as a neurosurgery nurse practitioner at the University of Louisville, Department of Neurological Surgery. She has served as adjunct faculty at Midway College, where she taught neurotrauma and general neurology topics. Kim now works at the Defense and Veterans Brain Injury Center, which is the operational TBI component of the Defense Center of Excellence. She has been an active member of many nursing organizations, and is currently on the Board of Directors of the American Board of Neuroscience Nurses. Kim lectures widely and has co-authored many peer-reviewed papers on topics including TBI, post-traumatic stress disorder (PTSD) following TBI, spinal cord injury, the promotion of cerebral perfusion, and the management of cerebral edema. Her work has been recognized with certificates of appreciation from the Kentucky Organ Donor Affiliates, the Brain Injury Association of Kentucky, and the Health & Human Services Administration Organ Donation Breakthrough Collaborative.

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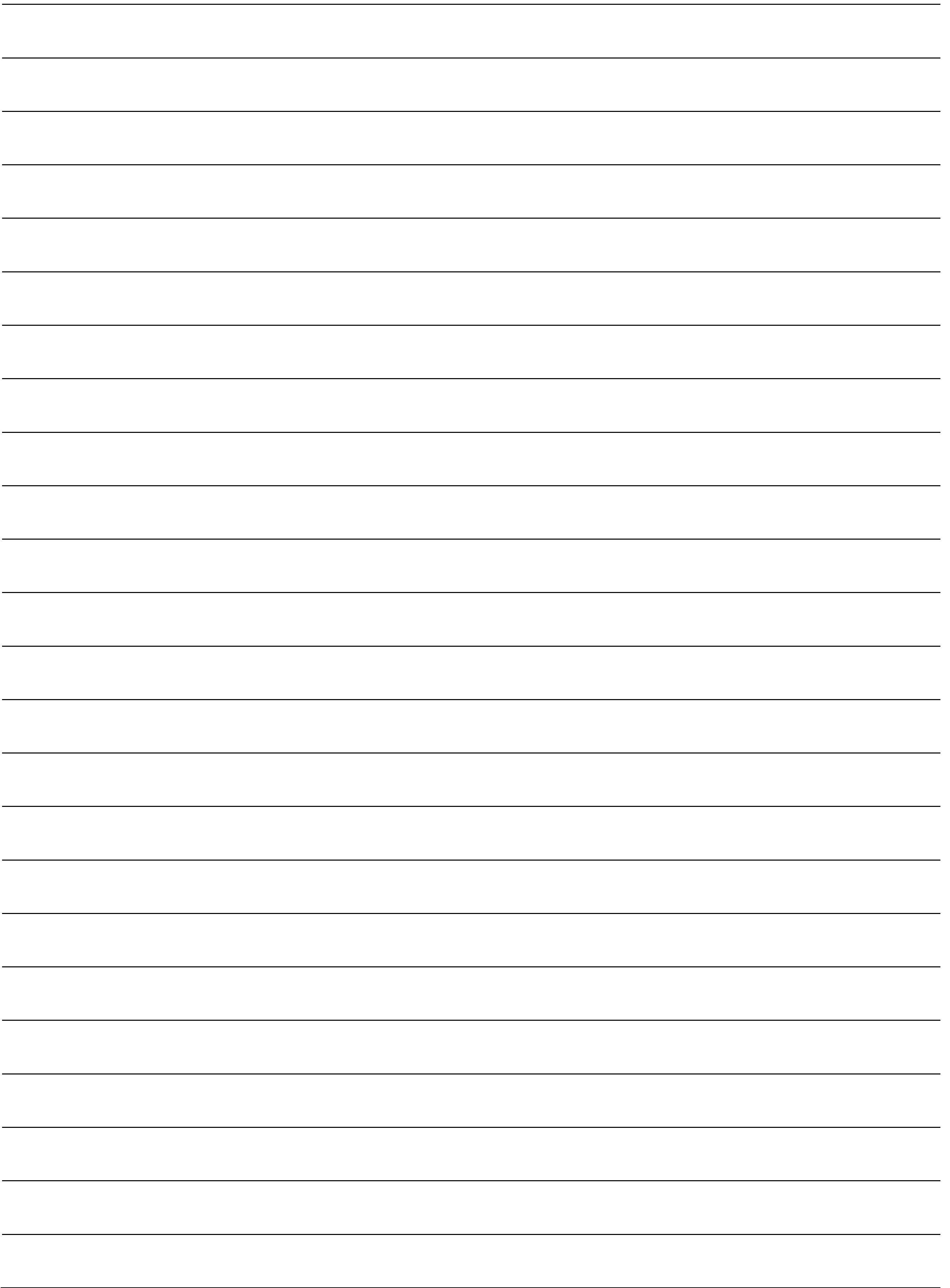

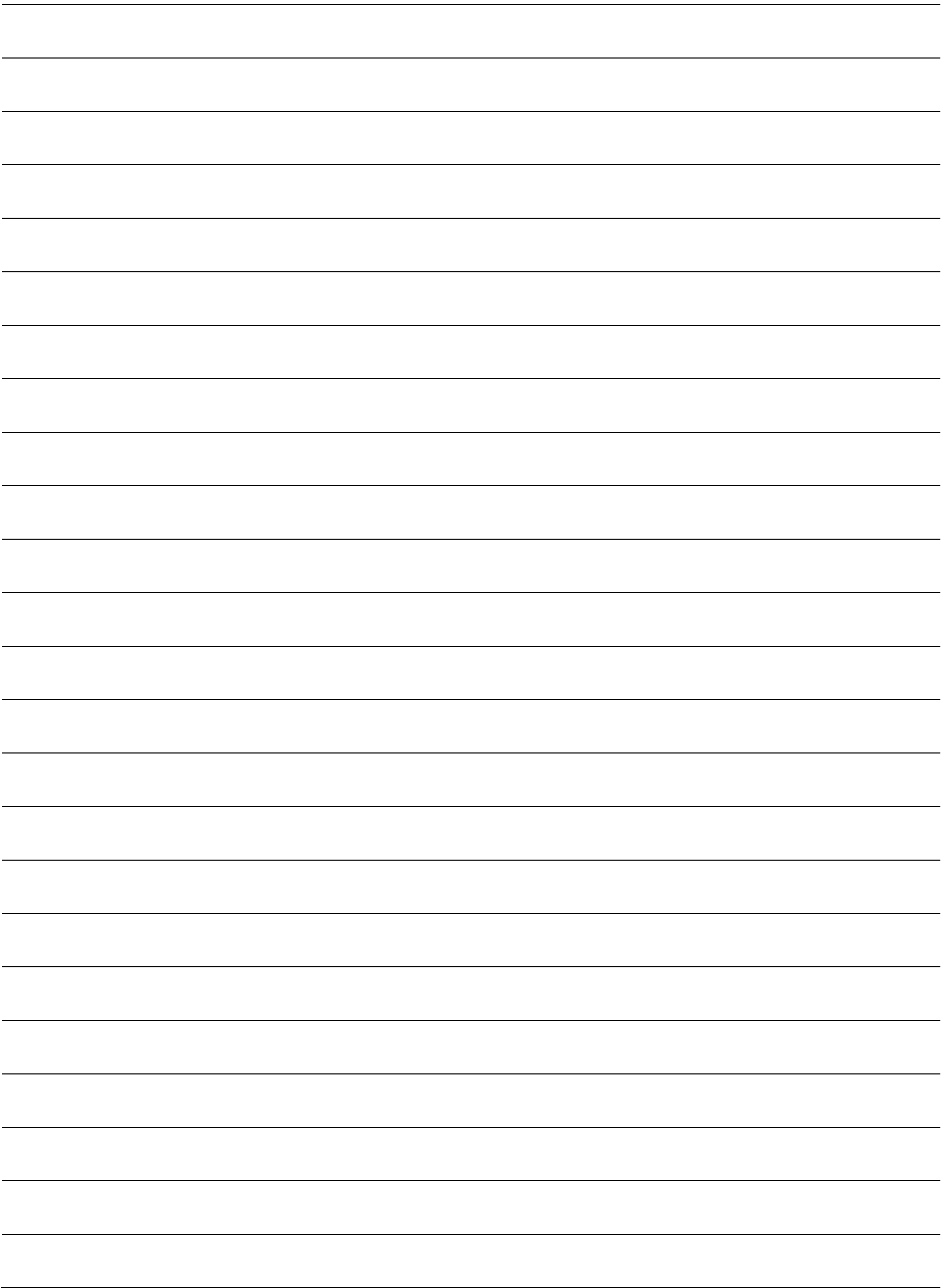

THURSDAY, APRIL 8

7:30 AM – 9:00 AM Opening Session & Welcome – Leadership and Collaboration

Orange Ballroom E-G

Moderator – President-Elect Betsy Seislove, RN, MSN, CCRN

President's Address & Annual Meeting

Your voyage of discovery starts here, with the Annual Meeting and President's address. This session is open to all full conference attendees. STN President, Sue Cox, will give an update of STN activities, introduce the Board of Directors, and discuss leadership strategies for trauma nurses. This session includes the presentation of STN Awards. Explore and learn more about STN and what it means to be an active member.

Session Objective: List three things that STN members – and all trauma nurses – can do to promote leadership styles that will advance trauma care and trauma patient outcomes.

Susan A. Cox, RN, MS, CEN, PHN

STN President & Rady Children's Hospital and Health Center San Diego, California

Sue Cox is the current president of the Society of Trauma Nurses (STN). She is the Director of Rady Children's Hospital Regional Pediatric Trauma Center in San Diego, and also directs the department of Volunteer Services there. Sue is the immediate past Chair of the San Diego County Trauma Program Managers and the first nursing co-chair of the San Diego County Medical Audit Committee. She is also the Treasurer of the Trauma Research and Education Foundation of San Diego. Sue received her BSN from San Diego University with a minor in Business Administration, and her MS from San Diego State University in Nursing Administration. She has been an active clinician, administrator, and educator for the past 30 years, focusing exclusively on pediatric issues with primary interests in critical care, trauma care, emergency care, disaster planning, and injury prevention. Sue is a prolific educator locally, nationally and internationally. Her work has been published in the Journal of Trauma Nursing, Nursing Clinics of North America, and in the Emergency Nurses' Association's Trauma Nurse Core Curriculum. She has been recognized for her advocacy with children's issues by the San Diego Office of Education, the San Diego Rotary Club, the YWCA, and Rady Children's Hospital.

Advancing Collaborative Trauma Care

All aspects of effective trauma care depend on successful team building and dynamics. Dr. Ernest Block welcomes STN to Orlando and explores ways to enhance team performance through communication, reinforcement, and ongoing evaluation.

Session Objective: Summarize key strategies for successful team building among nurses, physicians, and other trauma care providers.

Ernest J. Block, MD, MBA, EMT-P, FACS, FCCM

Holmes Regional Medical Center, Melbourne, Florida

Dr. Ernest Block is the Director of Acute Care Surgery at Holmes Regional Medical Center in Melbourne, Florida. He was raised in Montreal, Canada and received a Bachelor of Arts degree from Cornell University with a dual major in History of Art and Biochemistry. After receiving his MD degree at the University of Miami, Dr. Block completed a General Surgery residency at Albert Einstein Medical Center in Philadelphia and then returned to Miami for additional training as a Fellow in Trauma and Critical Care at Jackson Memorial. He is an active clinician and prior to his current position has served as the Trauma Director of the Level I Trauma Center at the Orlando Regional Medical Center in Orlando, Florida. He holds office in a number of academic surgical associations including the Eastern Association for the Surgery of Trauma (Past-President), the American College of Surgeons, the Florida Committee on Trauma (Vice-Chairman), and the Florida Chapter of the American College of Surgeons (President Elect). In 2002, after practicing for ten years as surgeon, Dr. Block attended night school to become an EMT so as to better relate to the prehospital team that brings the trauma center its patients. He regularly participates in "ride along" time with EMS and Fire-Rescue. Dr. Block attended the University of Tennessee Physician Executive MBA program to improve leadership skills, quality improvement tools and financial abilities.

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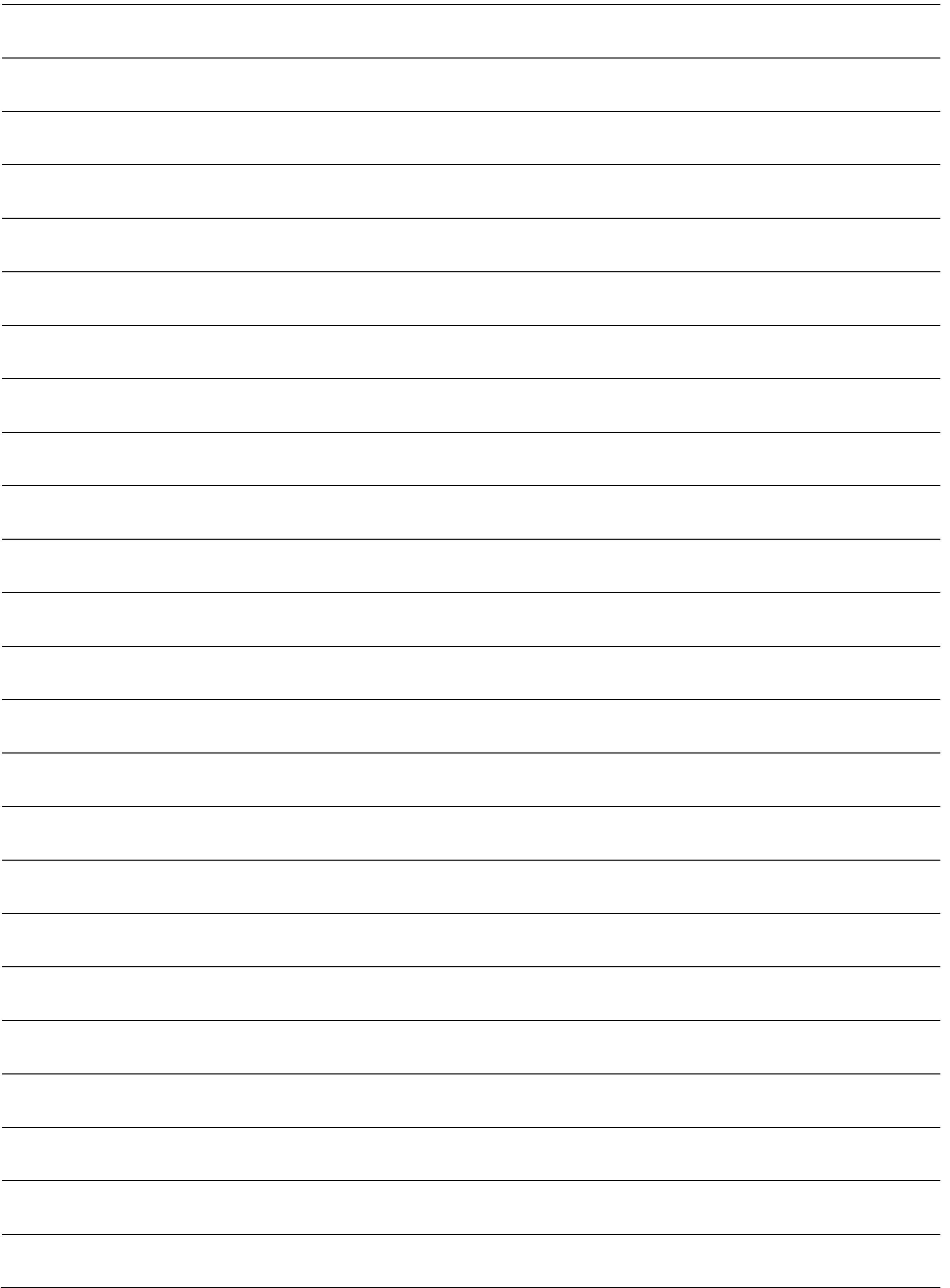

9:15 AM – 10:15 AM Concurrent Session: Rural Trauma Systems

Lake Concord

Moderator - Deb Syverson, RN, BSN, EMT

Injury Risk in Rural Communities: Perception versus Reality

Children who live in or visit rural areas are at increased risk of injury for a variety of cultural and environmental reasons. Rural America attracts those responding to the allure of wide open spaces for their recreational activities, including ATV's, snow mobiles, and water sports. However, these same landscape features – cliffs, steep drop-offs, rolling hills, lakes & rivers, and wooded areas - can increase injury risks for the young or inexperienced. Dr. Aitken discussed how that risk may be coupled with long distances to the nearest trauma center, or difficult EMS access to remote areas. Rural trauma care providers face serious challenges in these cases, including potential delays to the time of initial assessment and stabilization of the victim.

Session Objectives

1. Review injury risks that disproportionately affect children who live in rural environments.
2. Describe the magnitude of the problem of ATV and other recreational activity injuries in the U.S and prevention strategies.
3. Discuss the challenges confronting rural trauma providers in preventing and managing pediatric injury.

Mary Aitken, MD, MPH

Arkansas Children's Hospital, Little Rock, Arkansas

Dr. Mary Aitken is a general pediatrician practicing at Arkansas Children's Hospital (ACH) who is also a researcher. She is a Professor of Pediatrics University of Arkansas for Medical Sciences (UAMS), Section Chief of the Center for Applied Research and Evaluation in the Department of Pediatrics at UAMS, and the Medical Director of the ACH Injury Prevention Center. Dr. Aitken participates in resident and student education in the outpatient and inpatient setting. She is also involved in education of public health students as part of the Maternal and Child Health Division of the UAMS College of Public Health. Dr. Aitken serves on the Executive Committee for the Section on Injury, Poison, and Violence Prevention for the American Academy of Pediatrics. Her research interests include prevention of motor vehicle and all-terrain vehicle injury, as well as how to improve the quality of life of children after injury, particularly traumatic brain injury. She has received funding for her projects from the Emergency Medical Services for Children Program of MCHB and other agencies. She was the 2000 recipient of the American Congress of Rehabilitation Medicine's Sidney and Elizabeth Licht Award for Excellence in Scientific Writing. She also received a Robert Wood Johnson Generalist Physician Scholar award to advance her research program in evaluating health-related quality of life for injured children.

Dr. Aitken attended the University of North Carolina School of Medicine and completed a pediatrics residency at Johns Hopkins Hospital in Baltimore, Maryland. She also received a Master's in Public Health degree with a concentration in epidemiology during a General Academic Pediatrics fellowship at the University of Washington.

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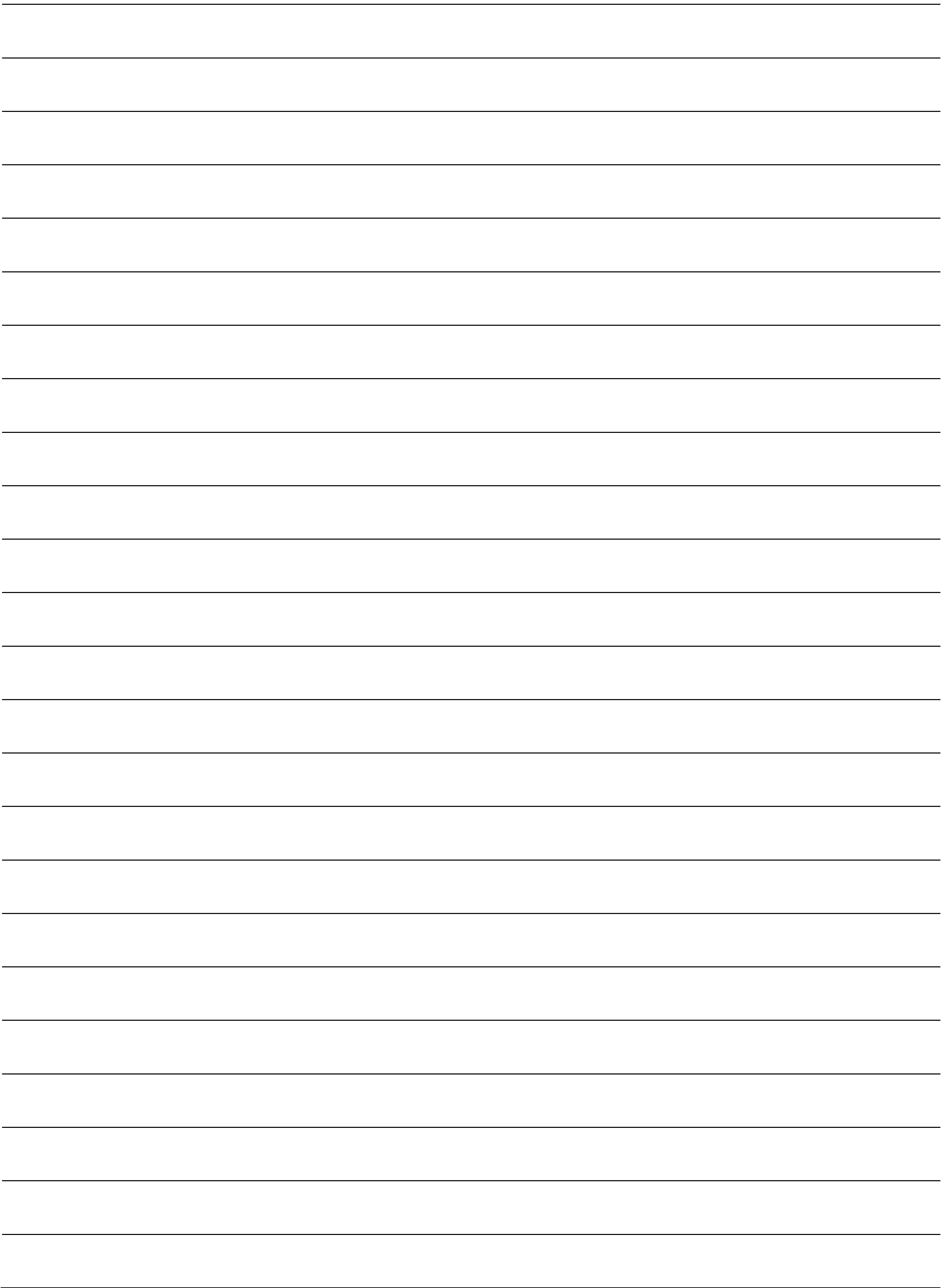

9:15 AM – 10:15 AM Concurrent Session: Disaster Management

Lake Hart

Moderator – Vicki Bennett, RN, MSN, CEN, CCRN

Top 10 Lessons Learned from Recent Disasters

Planning for disasters or mass casualty events is essential. The past 20 years have marked disasters of all types, from man-made to natural disasters. Whether the event was a bombing, biohazard, hurricane, flood, oil spill, wildfire, tornado, or bridge collapse, each event was marked by the lessons we learned about our vulnerabilities and our ability to respond. Michele Ziglar presents a recent history of disasters and disaster-preparedness, and challenges us to synthesize what we have learned as we prepare multi-hazard response plans to protect the safety of our citizens. Failure to prepare is preparing to fail.

Session Objectives

1. Examine key similarities in man-made and natural disasters.
2. Discuss key lessons learned from recent disasters.

Michele Ziglar, MSN, RN

Shands at the University of Florida, Gainesville, Florida

Michele Ziglar has dedicated her past 20 years of nursing to trauma program development and research. She is currently the Director of Trauma & Aeromedical Services at Shands at the University of Florida in Gainesville. She has been active in many professional organizations, including the Society of Trauma Nurses (STN), the Emergency Nurses Association (ENA), the American Trauma Society (ATS), and in regional and state trauma organizations. She is the current president of the Association of Florida Trauma Coordinators (AFTC) and Vice-President of the North Central Florida Trauma Agency (NCFTA). She is a previous board member and Education Committee Chair of STN. She is also a consultant/ site surveyor for the Pennsylvania Trauma Systems Foundation and the Colorado Department of Public Health and Environment.

Michele received her MSN in administration from the University of North Carolina at Greensboro. She has been the recipient of multiple awards, including an Annual Student Research Award and an MSN Student Excellence Award, both from Sigma Theta Tau International (Gamma Zeta Chapter). She has also received service and recognition awards from the ENA, STN, and ATS. Her busy career has spanned many roles, including bedside staff nurse, EMS and trauma educator and coordinator, regional trauma coordinator, trauma program manager and director, and trauma unit nurse manager. Throughout her career, she has presented at many national conferences.

She has coordinated many research and project grants, and has co-authored multiple publications in the care of trauma patients. Her areas of research interest include inter-hospital trauma transfers, telemedicine, hospital preparedness and mass casualty training, ICU surge capacity, burn training, hemorrhagic shock, resuscitation, the evaluation of cervical spine injuries, care of the obese trauma patient, and clinical decision making.

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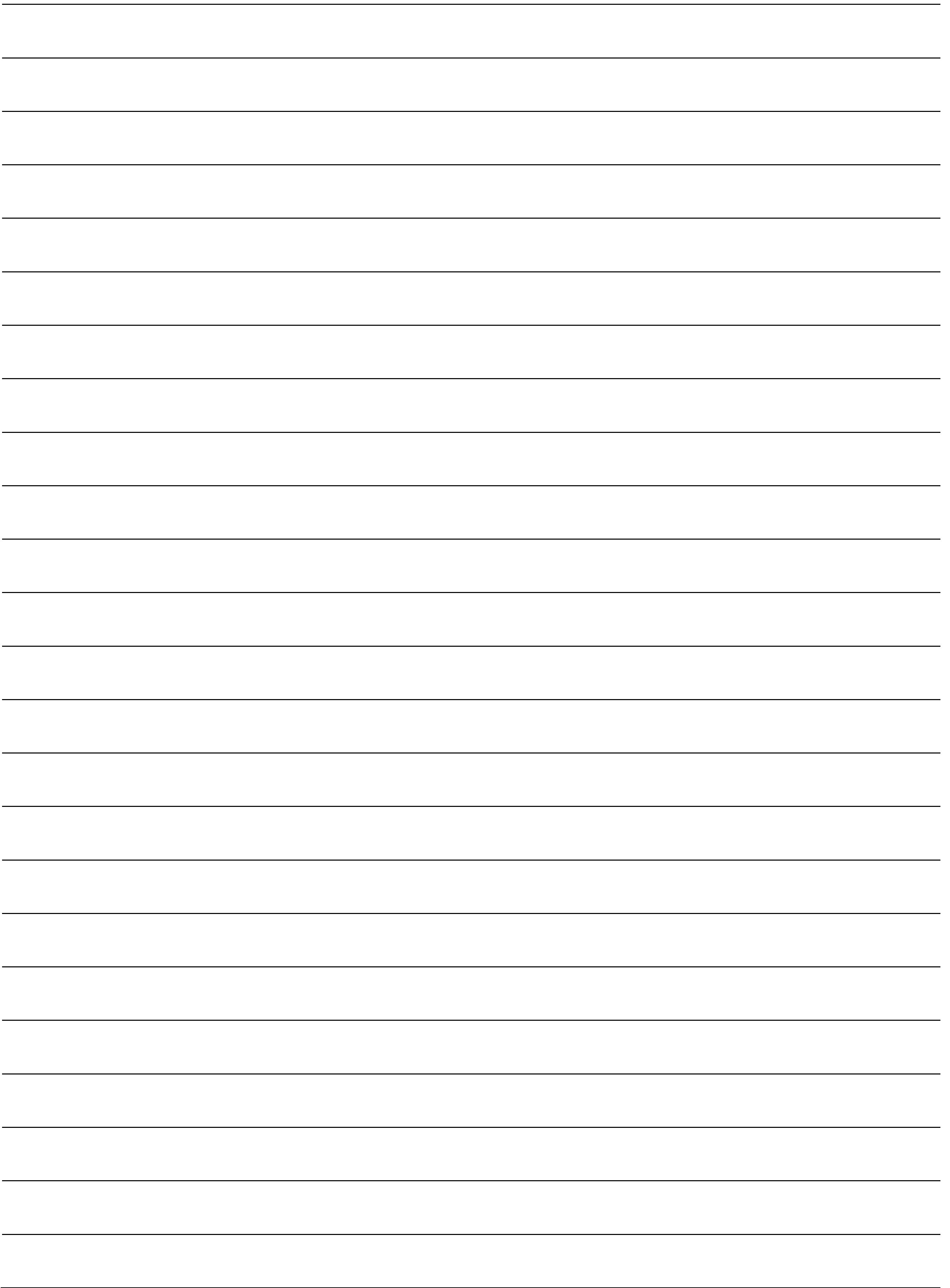

9:15 AM – 10:15 AM Concurrent Session: Oral Presentations

Lake George

Moderators –
Marie Dieter, MSN, RN, PHRN, CEN & Janice Delgiorno, MSN, RN, CCRN, ACNP – Co-chairs, Abstract Review Committee

Research

The top three submissions in the Research category are presented at this session.

R3 - ***Compare Pediatric Bowel Injuries from Trauma Requiring Surgical Intervention to Help Predict Outcome***
Maria F. McMahon, MSN, RN, CPNP-AC and David P. Mooney, MD, MPH

R5 - ***Is It Us or Them? Who Fails at Follow-up***
Nancy Martin, RN, MS, ACNP; Ajai K. Malhotra, MD; Melanie Jacoby, RN, BSN; Janie Tarrant, RN, BSN; Kelly Guilford, RN; and Rao Ivatury, MD

R11 - ***Seatbelt Compliance: Is Obesity a Factor?***
Amber Kyle, BSN, RN and Terri Gillespie, BSN, RN

Session Objectives

1. Review a sample of current research projects and papers in the field of trauma nursing
2. Discuss strengths and weaknesses of various approaches to trauma nursing research..
3. Rate the findings from these studies.

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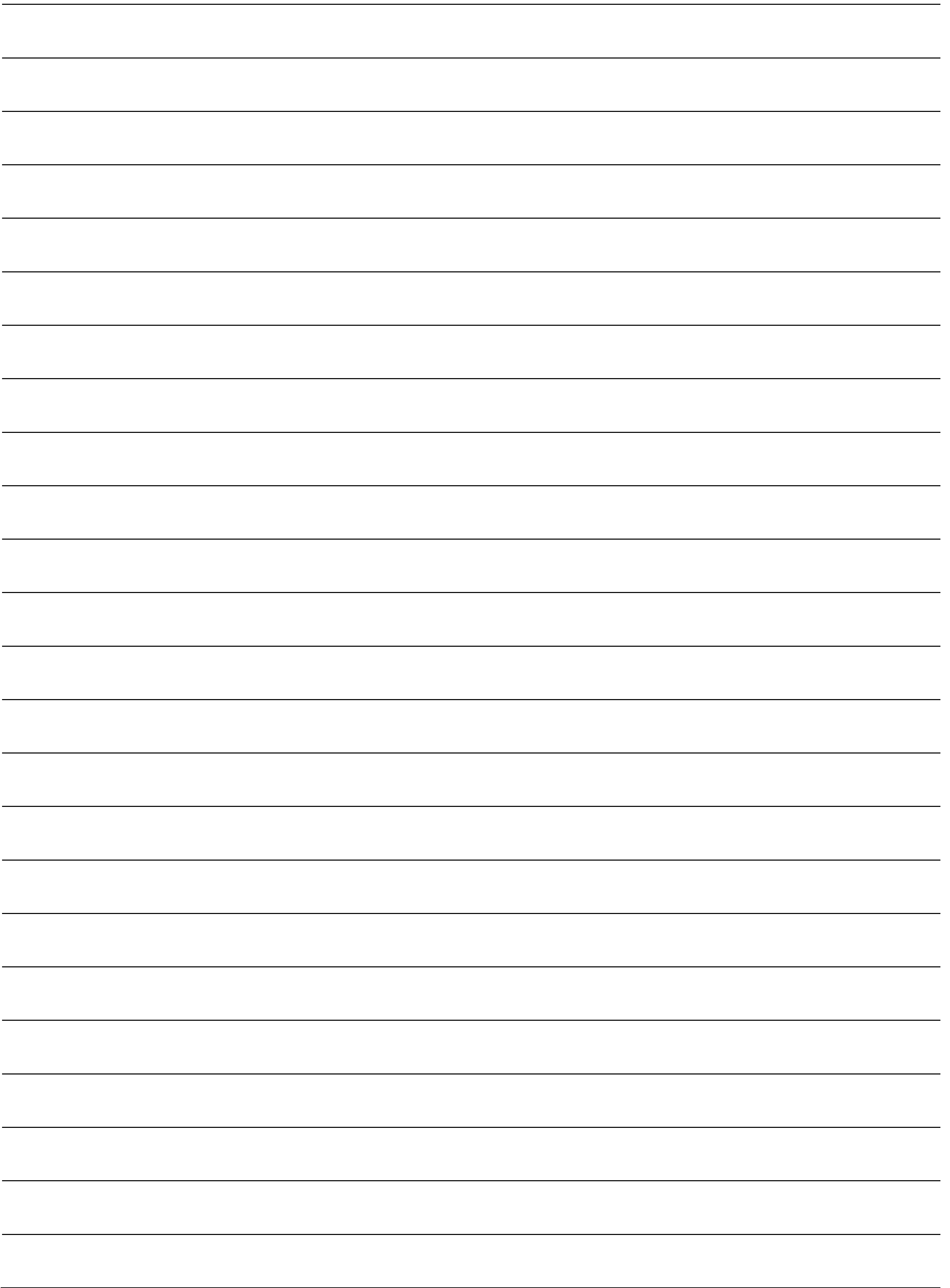


9:15 AM – 10:15 AM Concurrent Session: Challenging Cases

Lake Down

Moderator-Betsy Seislove, RN, MSN, CCRN

Delirium & Psychosis in the ICU

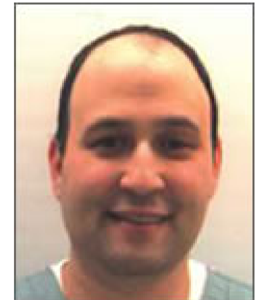
Critical care nurses have long observed the delirium and "ICU psychosis" experienced by some patients, which was historically felt to be inconsequential and reversible. Recent studies have found that delirium rates have been under-reported, and that delirium is associated with increased length-of-stay, higher mortality rates, and long-term cognitive impairment following critical illness. Dr. Cohen discusses the risk factors for delirium and psychosis in the ICU along with screening procedures and both pharmacological and non-pharmacological recommendations for treatment and prevention.

Session Objectives

1. Identify the common presentations & significance of delirium.
2. Describe different methods for the diagnosis of delirium
3. Explain the side effects of some common sedative agents which may affect delirium
4. Utilize the knowledge gained to make recommendations for reducing the impact of delirium at your institution

Jonathan B. Cohen, MD, FCCP

Tampa General Hospital and the University of South Florida, Tampa, Florida



Dr. Jonathan Cohen is a member of Florida Gulf-to-Bay Anesthesiology and works both in anesthesiology and critical care at Tampa General Hospital/ The University of South Florida. His commitment is 80% critical care, performing critical care duties with emphasis on post-operative care, including burn, trauma, neurosurgical, obstetric, abdominal transplant, and orthopedic patients. He is a board certified anesthesiologist with special qualifications in critical care. Dr. Cohen trained at the University of South Florida College of Medicine and completed his fellowship in critical care medicine there as well. He was the recipient of the Outstanding Anesthesiology Independent Study Project and the Annual Award for Excellence in Forensic Pathology, both in 2002. His poster presentation, "Organ Donation in the Burn Unit," won a Best in Category (Critical Care) award at the American Burn Association 2009 Annual Meeting. He has published several papers, posters, and book chapters, including recent book chapters on the pathophysiology of shock in trauma and on clinical decision-making.

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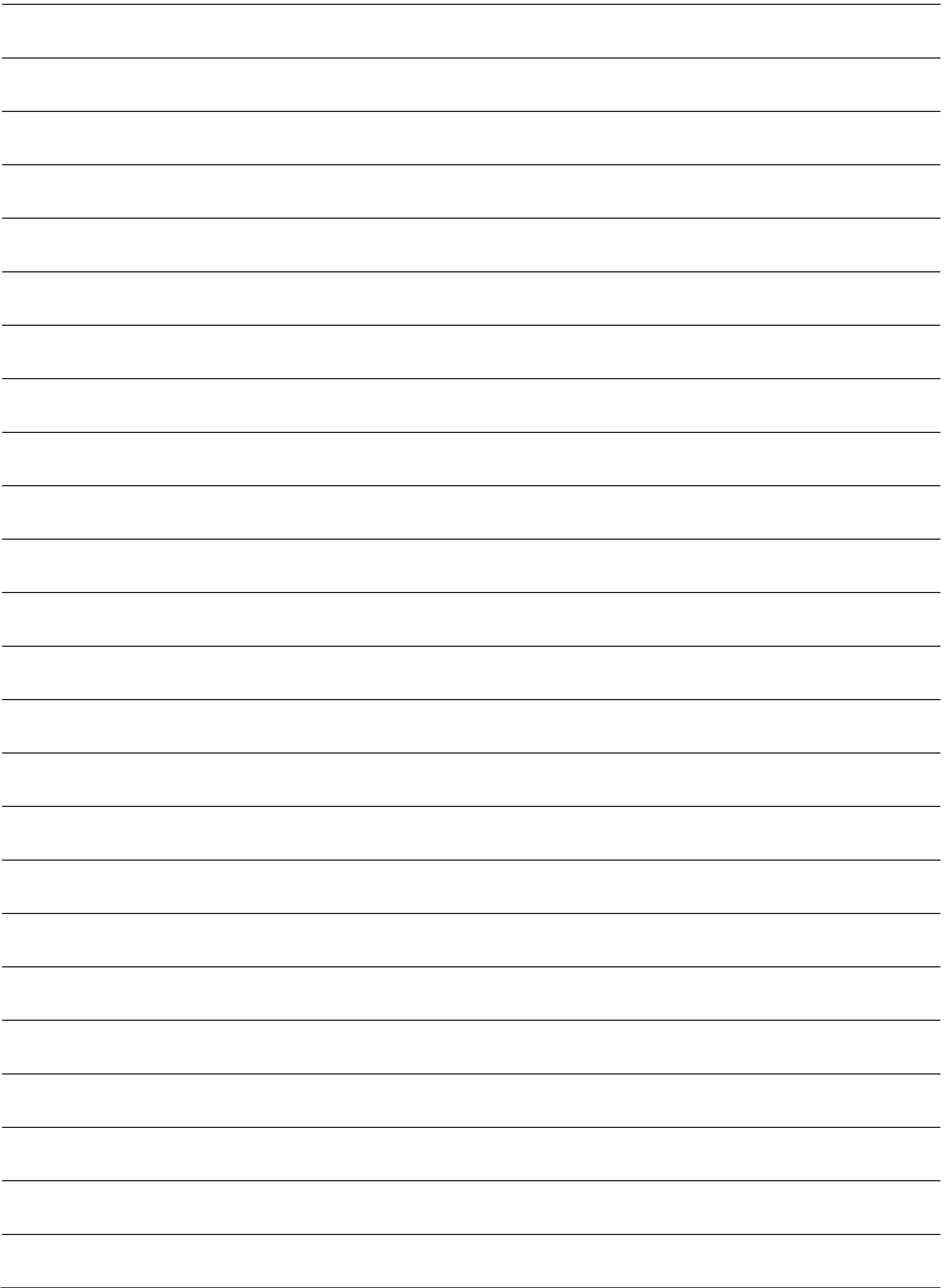

10:30 AM – 11:30 AM Concurrent Session: Pharmacology

Lake Concord

Moderator – Dianna Liebnitzky, MS, BSN, LNCC, CEN

Recombinant Factor V11a

Recombinant factor VIIa has become very popular in the treatment of traumatic bleeding, in spite of its significant cost. But what does the evidence show about its efficacy in various clinical situations? Laura Criddle will discuss which patients benefit most from rFVIIa, along with its indications, complications, pros-and-cons, and nursing implications.

Session Objectives

1. Identify the indications for recombinant factor VIIa and its pharmacologic actions
2. Explain the current state of the evidence regarding rFVIIa efficacy and describe controversies surrounding rVIIa administration.
3. Discuss nursing issues associated with rFVIIa administration.

Laura Criddle, PhD, RN, ACNS-BC, CCRN, CCNS, CNRN, CEN, CFRN, CPEN, ONC, NREMT-P, FAEN

Laurelwood Consulting, Scappoose, Oregon

Dr. Laura Criddle is a clinical nurse at Oregon Health & Science University, Portland Oregon and a clinical nurse specialist at the Laurelwood Group, Scappoose Oregon. She attended nursing school in a quiet suburban community and went from there to a huge medical center in Harlem, where a fascination with the critically ill and injured patient began. This led her to practice in trauma centers from coast-to-coast, and to a career as a clinical nurse specialist in emergency and trauma care. She has held many leadership positions in nursing, including the editorial board of the Journal of Emergency Nursing and a member of the Certified Emergency Nurse (CEN) exam construction and review committee. She has also served as past president of the Oregon Emergency Nurses Association and is the 2010 Chair of the Academy of Emergency Nursing. Dr. Criddle earned her masters degree from the University of California, San Francisco in 1990 and returned to graduate studies to complete a PhD in nursing from Oregon Health & Science University in Portland in 2008. Her areas of primary interest include emergency, trauma, neuroscience, transport, geriatric injury, and critical care. She brings her wide experience in settings from critical care float pool to flight nurse, along with a tremendous breadth of knowledge, to any talk she gives. She has published extensively, including over 60 professional manuscripts, and is the co-editor of the 6th edition of Sheehy's Manual of Emergency Care.

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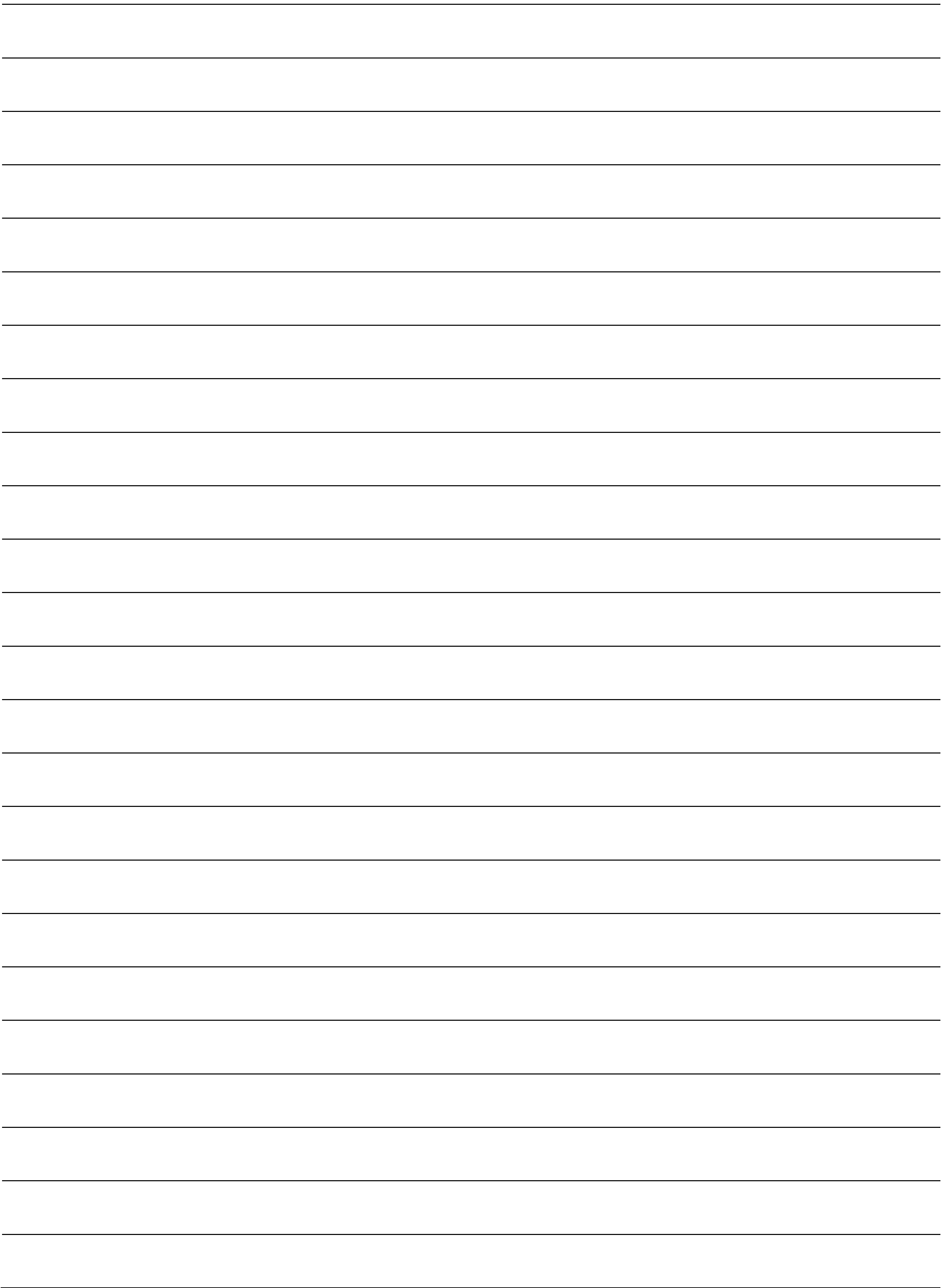

10:30 AM – 11:30 AM Concurrent Session: Pediatrics

Lake Hart

Moderator – Mary Jo Pedicino, MSN, RN

Fetal Trauma – The Other Side of Trauma in Pregnancy

For all intents and purposes, the assessment and management of the pregnant trauma patient is no different than that for the non-pregnant patient. What has changed over time is the emerging field of fetal trauma management. Gone are the days when the only assessment we had for the unborn was fetal heart tones. Cindy Blank-Reid discusses common fetal injuries - both blunt and penetrating - as well as the options available for their evaluation and intervention.

Session Objectives

1. Identify the 3 most common types of traumatic fetal injuries.
2. Formulate a plan of care of nursing intervetnion of mother and fetus who have experienced trauma

Cynthia Blank-Reid, RN, MSN, CEN

Temple University Hospital, Philadelphia, Pennsylvania

Cynthia Blank-Reid has been a nurse for over 25 years and is currently a Trauma Clinical Nurse Specialist at Temple University Hospital in Philadelphia. She received her undergraduate nursing degree from Villanova University and Master's Degree in Burn, Emergency and Trauma Nursing with a minor in neurosurgery from Widener University. She spent over 16 years at The Hospital of the Medical College of Pennsylvania (MCP) working in general surgery, neurosurgery, and the emergency department. She has worn many hats at their award-winning Level I trauma center, including trauma program coordinator and education and outreach coordinator. When MCP closed, Cindy moved to Temple University Hospital in Philadelphia, where she has been for the past 5 years. She has lectured locally and nationally on a multitude of nursing topics, and has published extensively. She is active in a variety of nursing organizations, including the Emergency Nurses Association (ENA), the American Association of Critical Care Nurses (AACN), Sigma Theta Tau (STT), the American Association of Neuroscience Nurses (AANN), and the Society of Trauma Nurses (STN). She has served as national president of AANN and is currently the chair of the STN Educational Committee.

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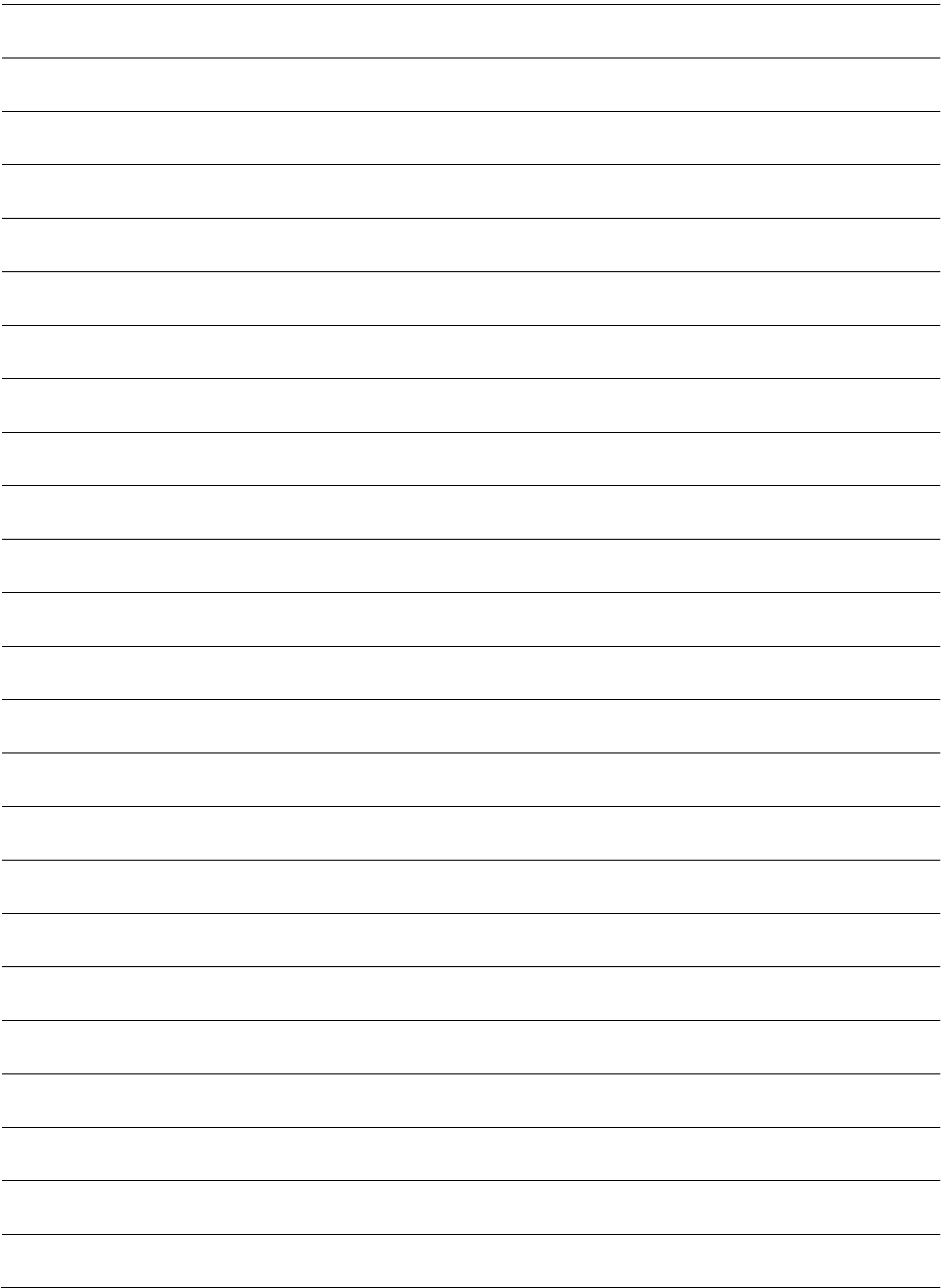

10:30 AM – 11:30 AM Concurrent Session: Oral Presentations

Lake George

Moderators –
Marie Dieter, MSN, RN, PHRN, CEN & Janice Delgiorno, MSN, RN, CCRN, ACNP – Co-chairs, Abstract Review Committee

Best Practices

The top three submissions in the Evidence-Based Practice category are presented at this session.

E4 - ***Development of a Geriatric Trauma Resuscitation Protocol, Utilization Compliance, and Outcomes***
Pamela Bourg, RN, MS; Melissa Richey, RN, BSN; Kristin Salottolo, MPH; and Charles W. Mains, MD

E7 - ***Erase the Pain: Initial Pain Management in the Trauma Resuscitation Bay***
Cynthia J Mastropieri, RN, MSN, CNS; Ginger Cunningham, RN; Dana R. Kennedy, RN, BSN; and Michael Foreman MD, FACS

E9 - ***Financial Implications of Trauma: Development of a Trauma Billing Committee***
Michael Jordan, MSN, MBA, HC

Session Objectives

1. Review a sample of current evidence-based practice (EBP) projects and papers in the field of trauma nursing.
2. Discuss strengths and weaknesses of various interventions to improved trauma nursing practice.
3. Appraise the process of transferring EBP strategies from one trauma center to another.

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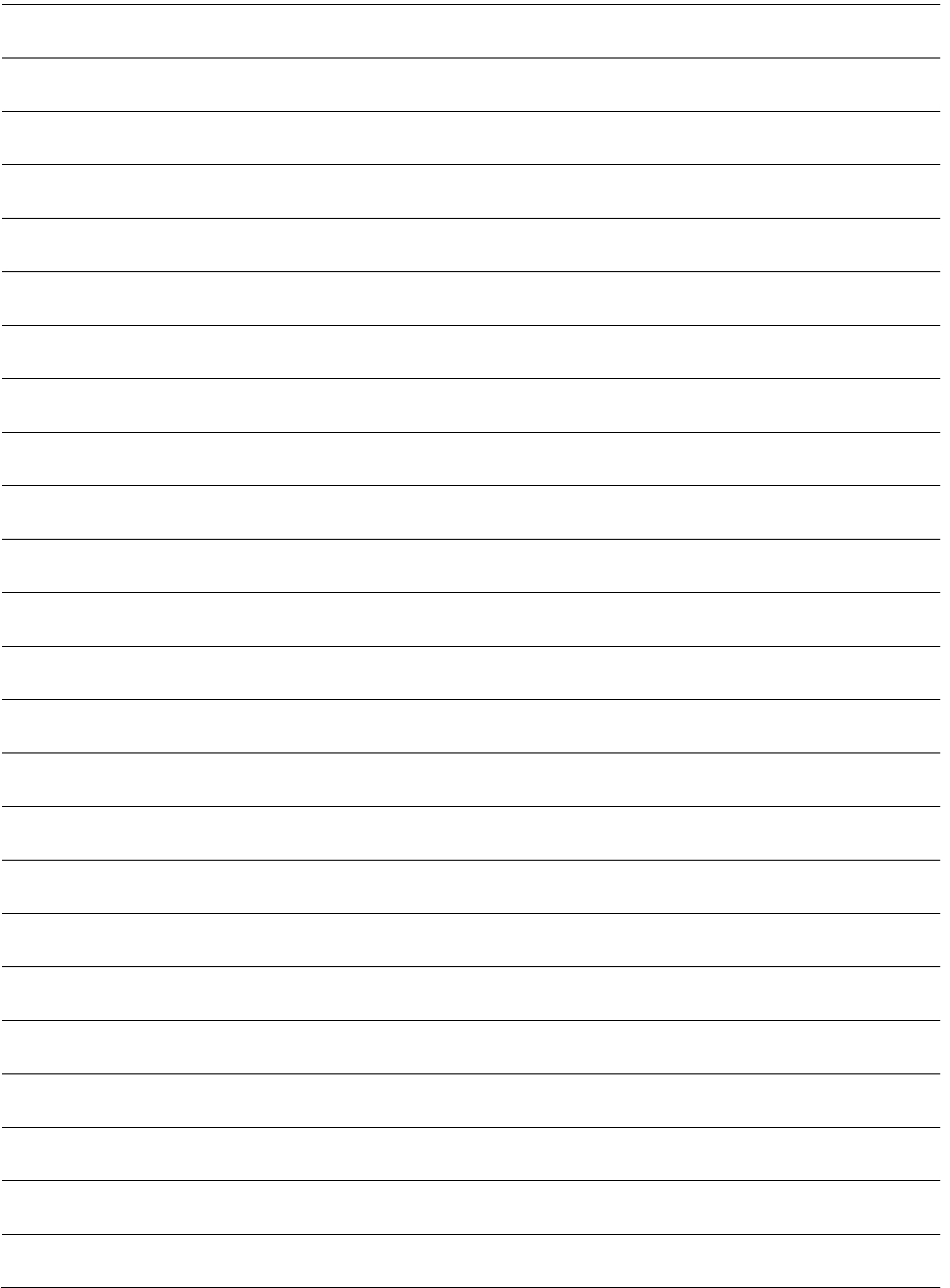


10:30 AM – 11:30 AM Concurrent Session: Prevention

Lake Down

Moderator – Ann Hoover, RN

What Makes an Alcohol Screening & Brief Intervention Program Successful?

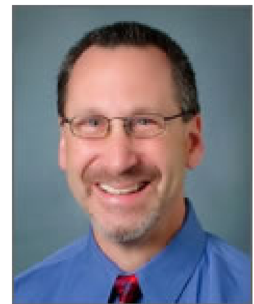
Alcohol use is so strongly associated with injuries that trauma centers are now required to provide alcohol screening and brief intervention programs. But not all centers follow up with patients to evaluate program efficacy over time. Dr. Vail describes positive results from one trauma center's program, as measured by decreased post-discharge AUDIT scores.

Session Objectives

1. Describe a high-risk drinker.
2. Define a "teachable moment" for high risk drinkers.
3. Recognize the benefits of a referral program for patients post-discharge.
4. Define strategies to develop or refine a screen and intervention program that lowers AUDIT scores and changes behaviors.
5. Describe how an alcohol and drug interventionalist is incorporated into the trauma team.

Sydney J. Vail, MD, FACS

Maricopa Medical Center, Phoenix, Arizona



Dr. Sydney Vail is the Medical Director of Trauma Services at Maricopa Medical Center in Phoenix, Arizona, where he has served since 2008. He is also the Medical Director of the Tactical Medicine Program at Maricopa. Dr. Vail completed his undergraduate training at George Washington University in Washington, DC with a major in zoology, and a master's degree in physiology from Georgetown University in Washington, DC. His medical school training was also completed at Georgetown University School of Medicine in Washington, DC, and his General Surgery residency was done at Albert Einstein Medical Center in Philadelphia, Pennsylvania. While in residency, he was the recipient of the first Frank H. Sivitz, MD Award for Outstanding Resident. Dr. Vail went on to complete two fellowships, one in Surgical & Trauma Critical Care and one in Trauma and Emergency Surgery, both from the University of Miami, Jackson Memorial Hospital, in Miami, Florida. He is board certified in both general surgery and surgical critical care. While on staff at Carilion Health System in Roanoke, Virginia, he was awarded the Annual House staff Award for Outstanding Teacher, the 2005 Celebration of Life Award from LifeNet –Virginia for Significant Contribution in the Area of Organ & Tissue Donation, and the Celebration of Heroes Award from the Roanoke Valley Chapter of the American Red Cross.

Dr. Vail has authored many peer-reviewed articles and textbook chapters, and his research and clinical interests include the management of thoracic and abdominal injuries, wound ballistics, tactical medicine, organ donation, nutritional aspects of critical care management, and the regionalization of critical care services. He is a nationally recognized speaker and has participated in multiple conferences.

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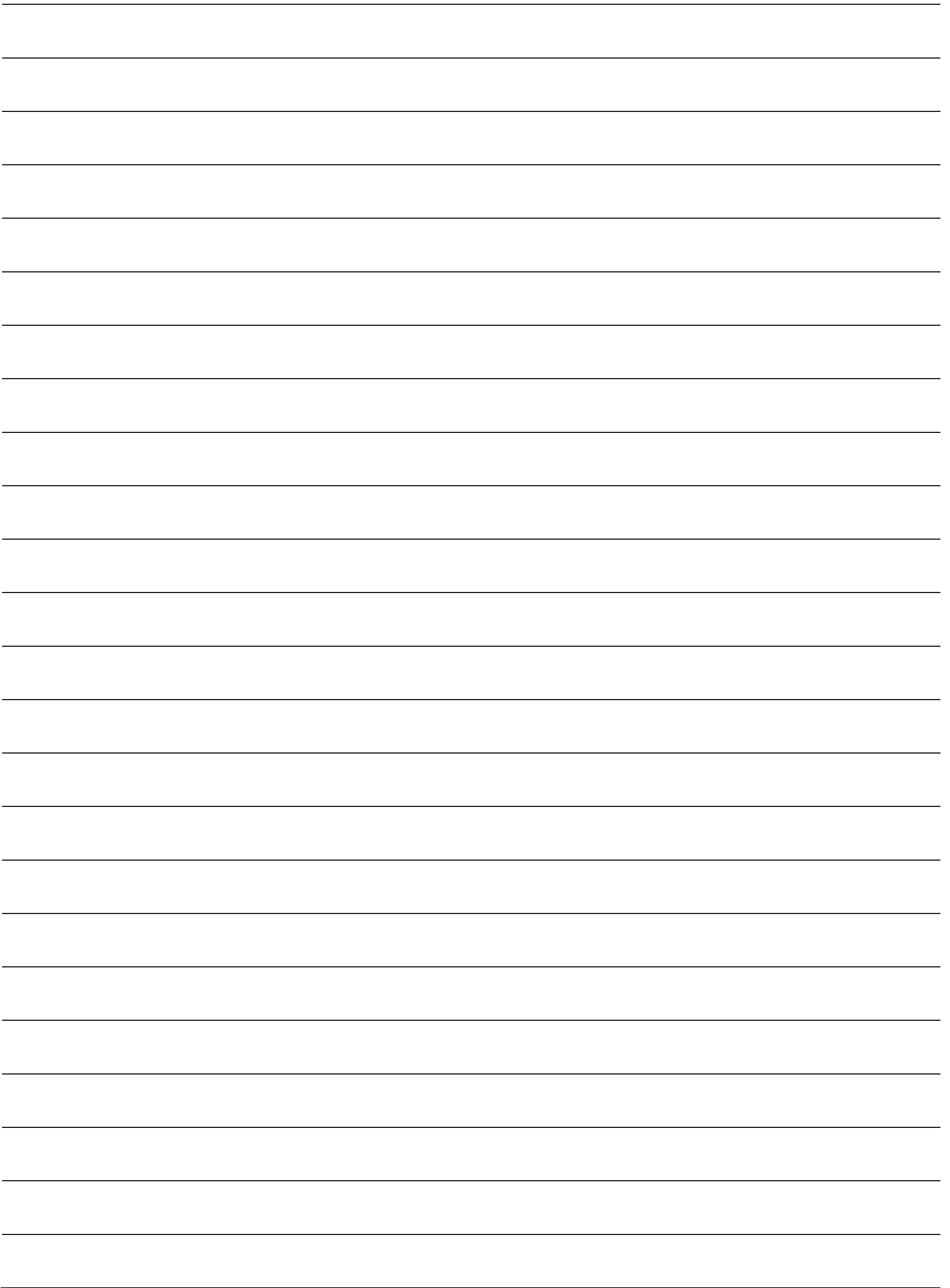

1:30 PM – 3:00 PM Neurotrauma SIG & Business Meeting

Optional Credit 1.0 CE

Lake Highland

E15 - ***To Reverse or Not to Reverse: Warfarin Reversal in the Traumatic Brain Injured Trauma (TBI) Patient***

Laurie L. Flowers, RN, MSN, CCRN, CCNS and Daneen Mace-Vadjunec, RN, BSN, ONC

Session Objective: Discuss one method for implementing a practice guideline for rapid reversal of anticoagulation in the presence of TBI.

A State-Wide Initiative to Standardize Initiation of Anticoagulation Reversal

Donna Mower-Wade, RN, MS, ACNS-BC

Session Objective: Describe the value of early reversal of anticoagulation in the traumatic brain injured (TBI) patient.

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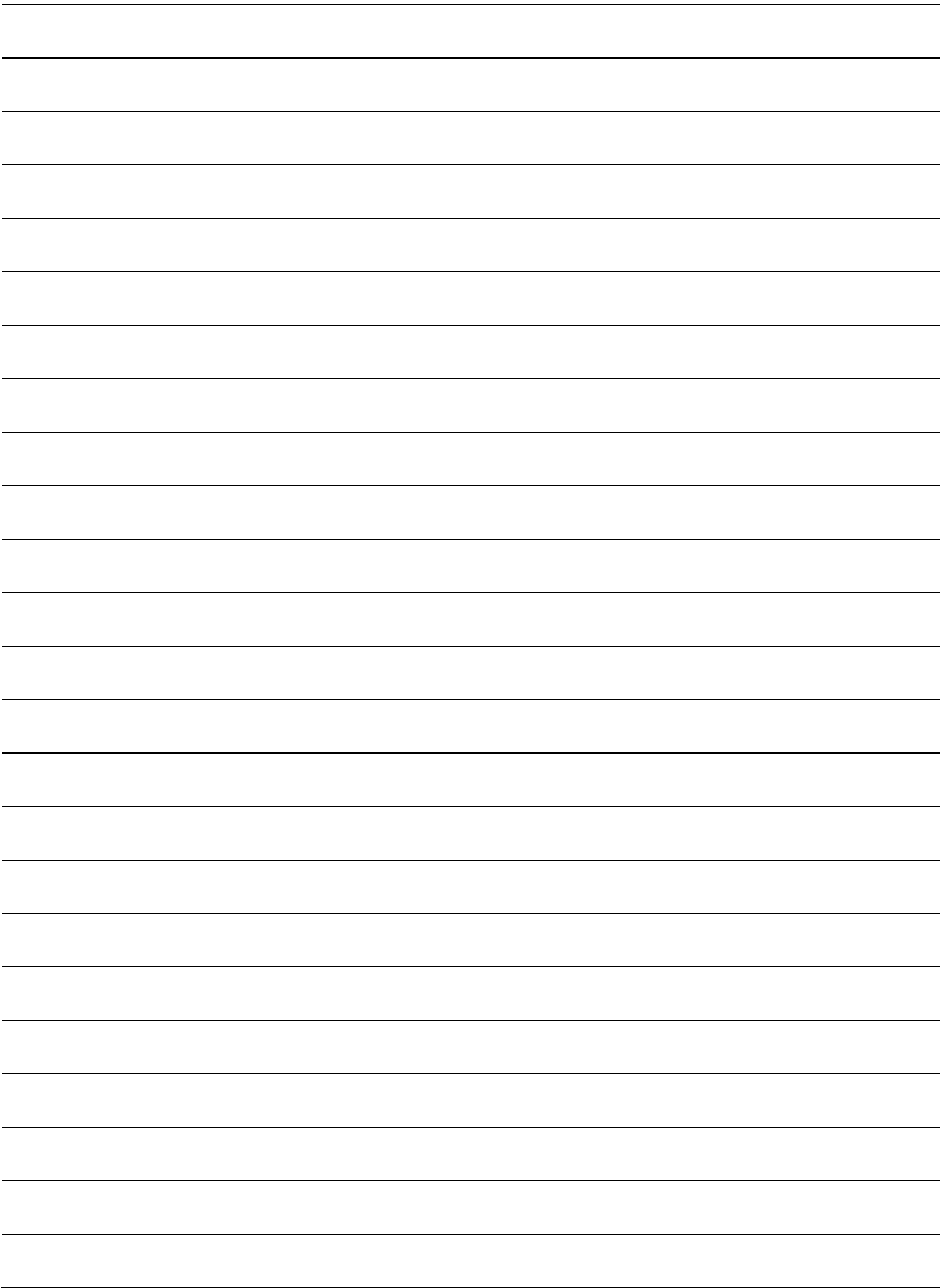

THURSDAY, APRIL 8

1:30 PM – 3:00 PM Injury Prevention SIG & Business Meeting

Optional Credit 1.0 CE

Lake Lucerne

E14 - ***SBIRT in a Pediatric Trauma Center: How and Why?***

Roni L. Robinson, RN, MSN, CRNP and Kara Noto, MSW, LSW

Session Objectives

1. Review the background and purpose of SBIRT in the Trauma Center.
2. Describe one approach to the SBIRT process that was implemented by a children's trauma center.
3. Discuss implications of SBIRT for adolescent trauma patients.

R9 - ***Patient Teaching Materials on the Risk of Falling While Anticoagulated: Is Consumer Input Useful?***

Sheree Brown, BSN, RN; Madonna R. Walters, MS, RN; Mary-Anne Purtill, MD, FACS; and Richard Pomerantz, MD, FACS

Session Objectives

1. Identify key aspects of designing a consumer survey study.
2. Discuss the development of an appropriate survey tool.
3. Assess the value of consumer survey sampling in the process of designing patient educational materials.

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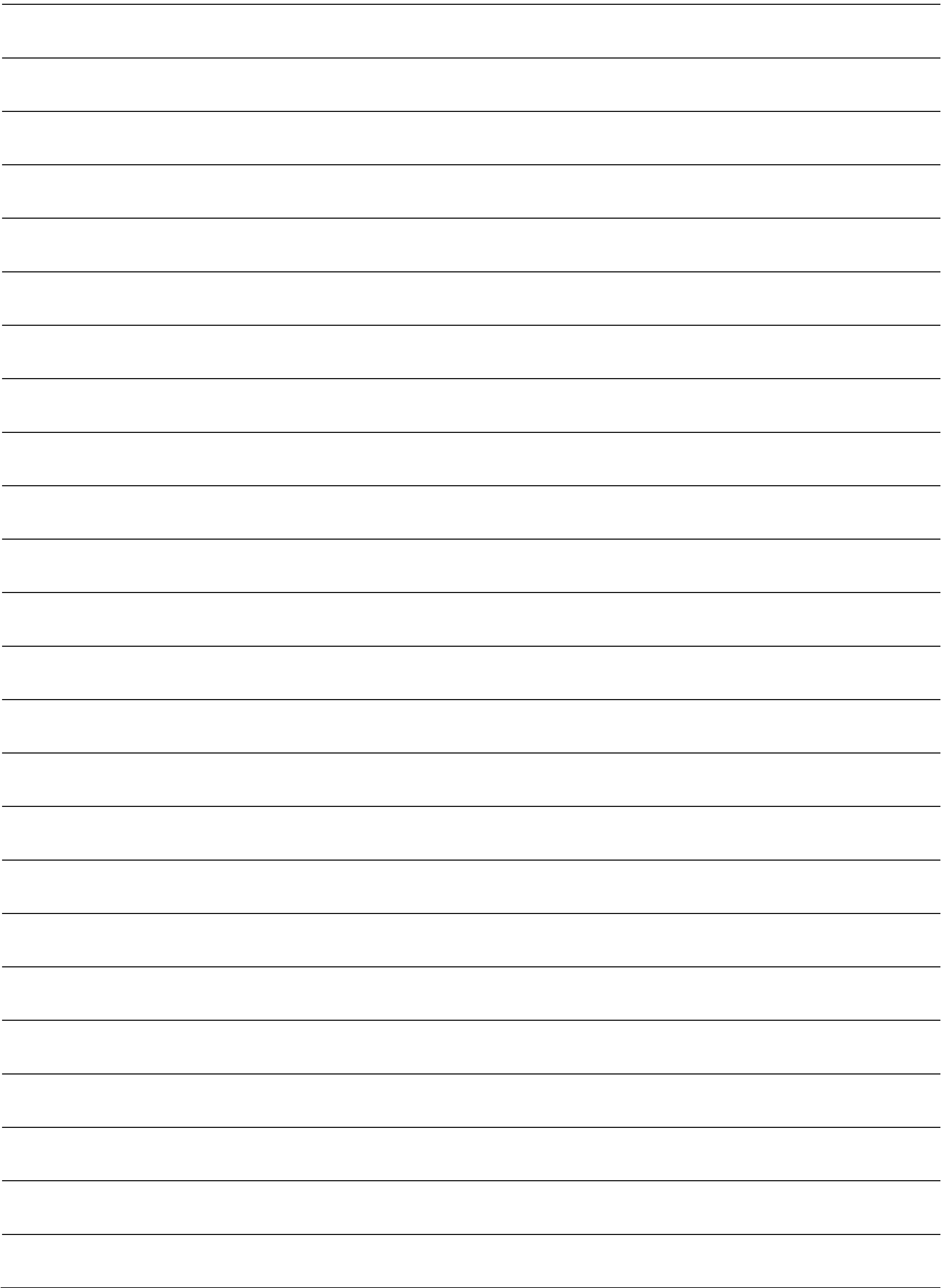

1:30 PM – 3:00 PM Pediatric SIG & Business Meeting

Optional Credit

1.0 CE

Lake Concord

How do you do that?

To provide pediatric trauma nurses and pediatric trauma care providers with the up to date information and tools to enhance the provision of optimal trauma care to pediatric trauma patients

Session Objectives

1. Identify challenges encountered by Trauma Program Managers when leading a pediatric trauma program.
2. Discuss methods used to resolve challenges encountered by Trauma Program Managers when leading a pediatric trauma program
3. Summarize various perspectives toward problem resolution in pediatric trauma center management.

Panel Discussion –

Deb Brown, RN, BSN
Dell Children's Hospital

Michael Jordan, MSN, MBA, HC
Children's Hospital of Los Angeles

Chris McKenna, MSN, RN, CRNP
Children's Hospital of Pittsburgh of UPMC

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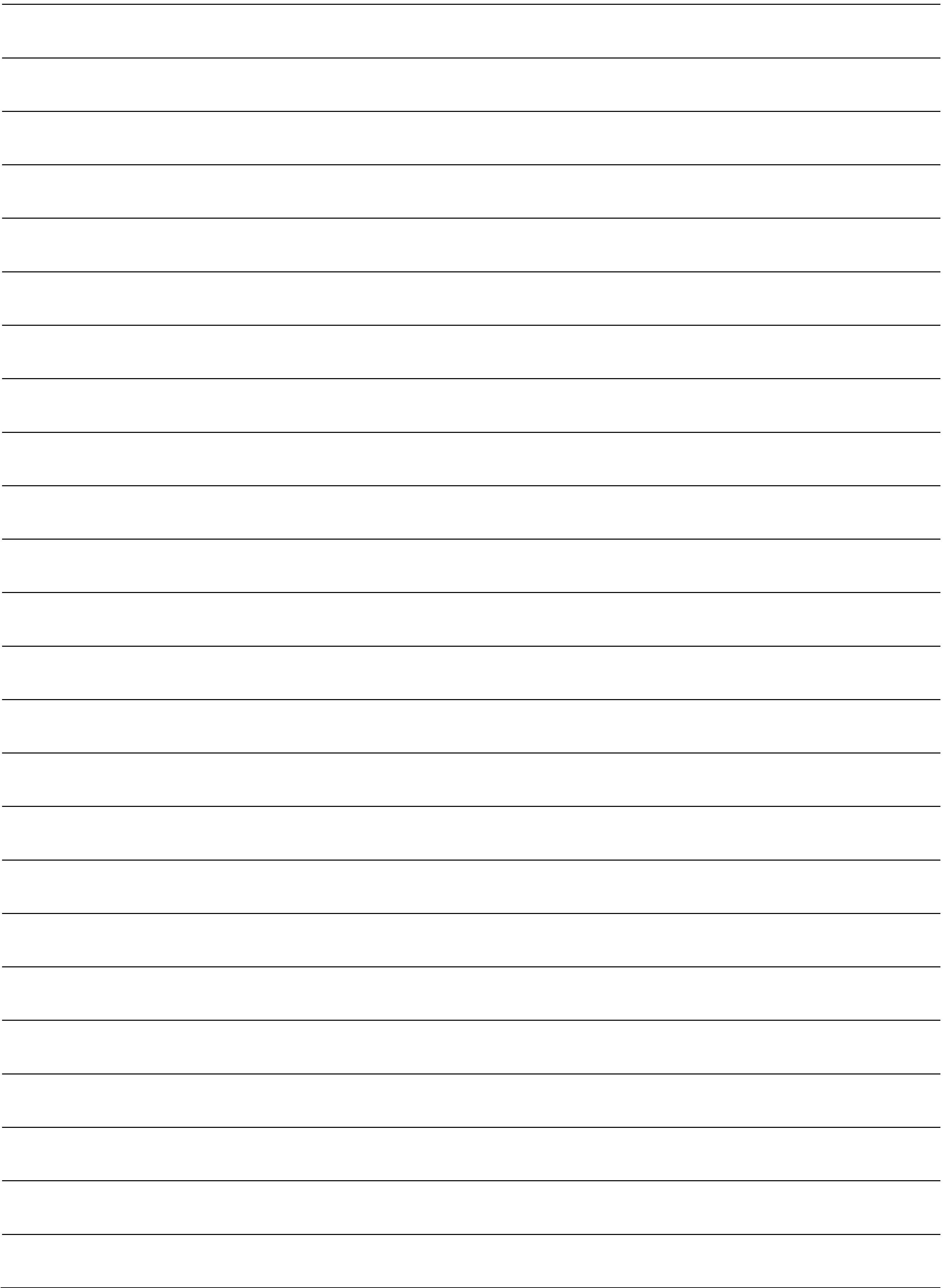

THURSDAY, APRIL 8

1:30 PM – 3:00 PM Advanced Practice SIG & Business Meeting

Optional Credit 1.0 CE

Lake Hart

E1 - ***Advanced Practitioner Comprehensive Tertiary Survey including Incidental Findings: Improved Communication and Reduction of Missed Injuries***

Amanda McNicholas, MSN, CRNP; Tara Collins, MSN, CRNP; and Susan Butler, MSN, RN, CCRN

Session Objective: Describe how a streamlined tertiary survey procedure can help trauma primary care providers to decrease their rates of missed injuries.

Implementation of Screening and Brief Intervention Related to Trauma (SBIRT) at a Pediatric Trauma Center

Dana Noffsinger, MS, CPNP-AC/PC

Session Objectives

1. Describe the rationale for SBIRT.
2. List options for screening tests: laboratory, questionnaires and interviews.
3. Describe barriers to implementation of SBIRT.

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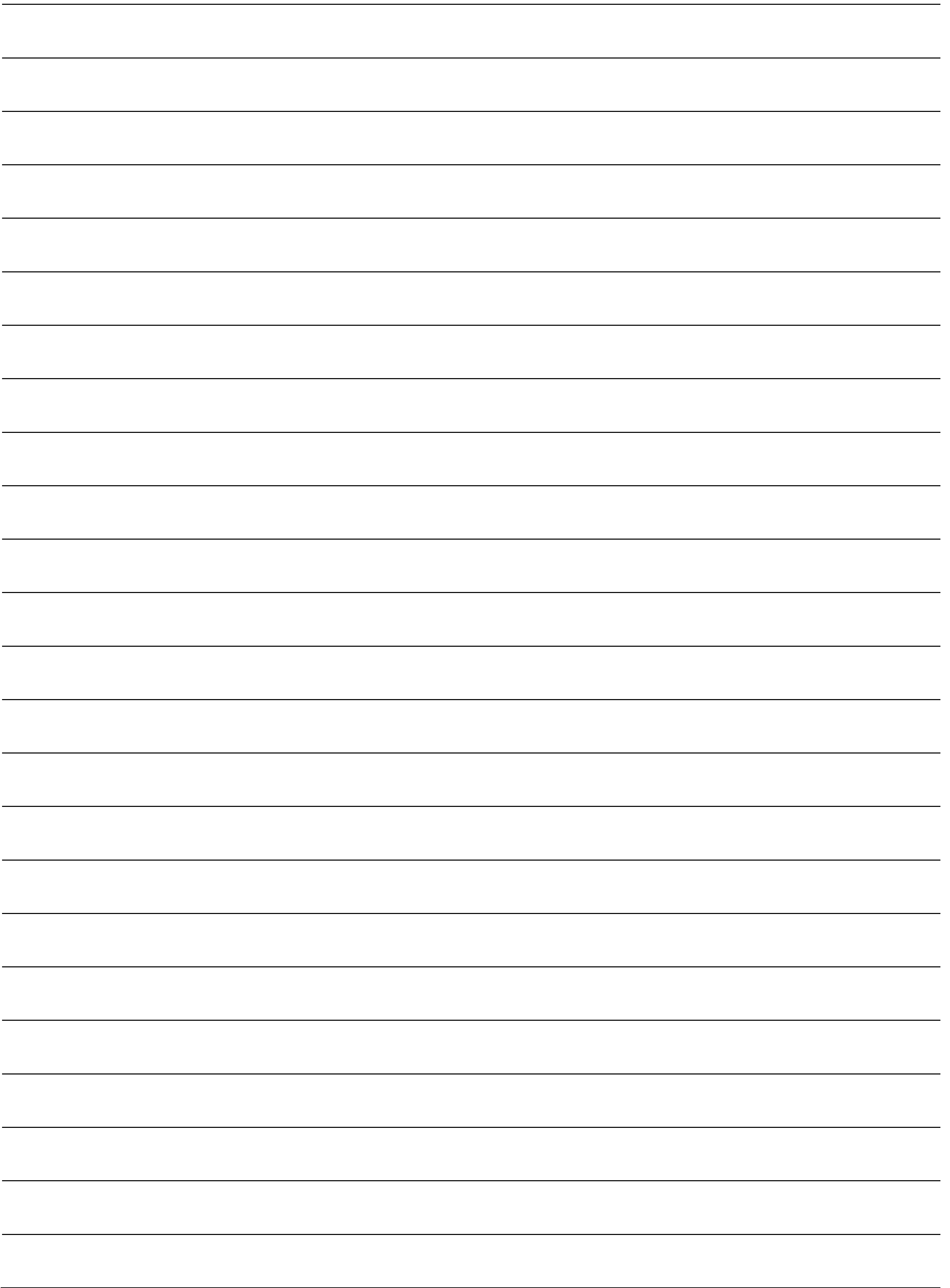

THURSDAY, APRIL 8

1:30 PM – 3:00 PM Military SIG & Business Meeting

Optional Credit 1.0 CE

Lake George

E2 - ***Aeromedical Evacuation to Landstuhl Regional Medical Center: Opportunities for Improvement***

Kathleen Martin, RN; Liz Schell, RN; Raymond Fang, MD; Beth Cleek, RN; Connie Johnson, RN; Sean Kelley, RN; Sheryl Neal, RN; and Pam Nyman, RN

Session Objectives

1. Describe to the challenges of implementing an effective performance improvement (PI) program between aeromedical providers and trauma center staff.
2. Summarize the ground and air provider values that influence the transport of wounded warriors across the continuum of combat casualty care.

R2 - ***Caring for Wounded Warriors: Development of Performance Improvement (PI) Knowledge for Deployed Trauma Nurse Coordinators (TNCs)***

Rose Bolenbaucher, MSN, RN; Captain Lisa Compton, BSN, RN; Nancy Molter, RN, PhD; Joanna Moore, MPH; Mary Ann Spott, MPA, MBA; and Tracy Cotner-Pouncy, RN

Session Objective: Describe an educational plan for deployed trauma nurse coordinators that can reduce the number of performance improvement events (audit filters) identified.

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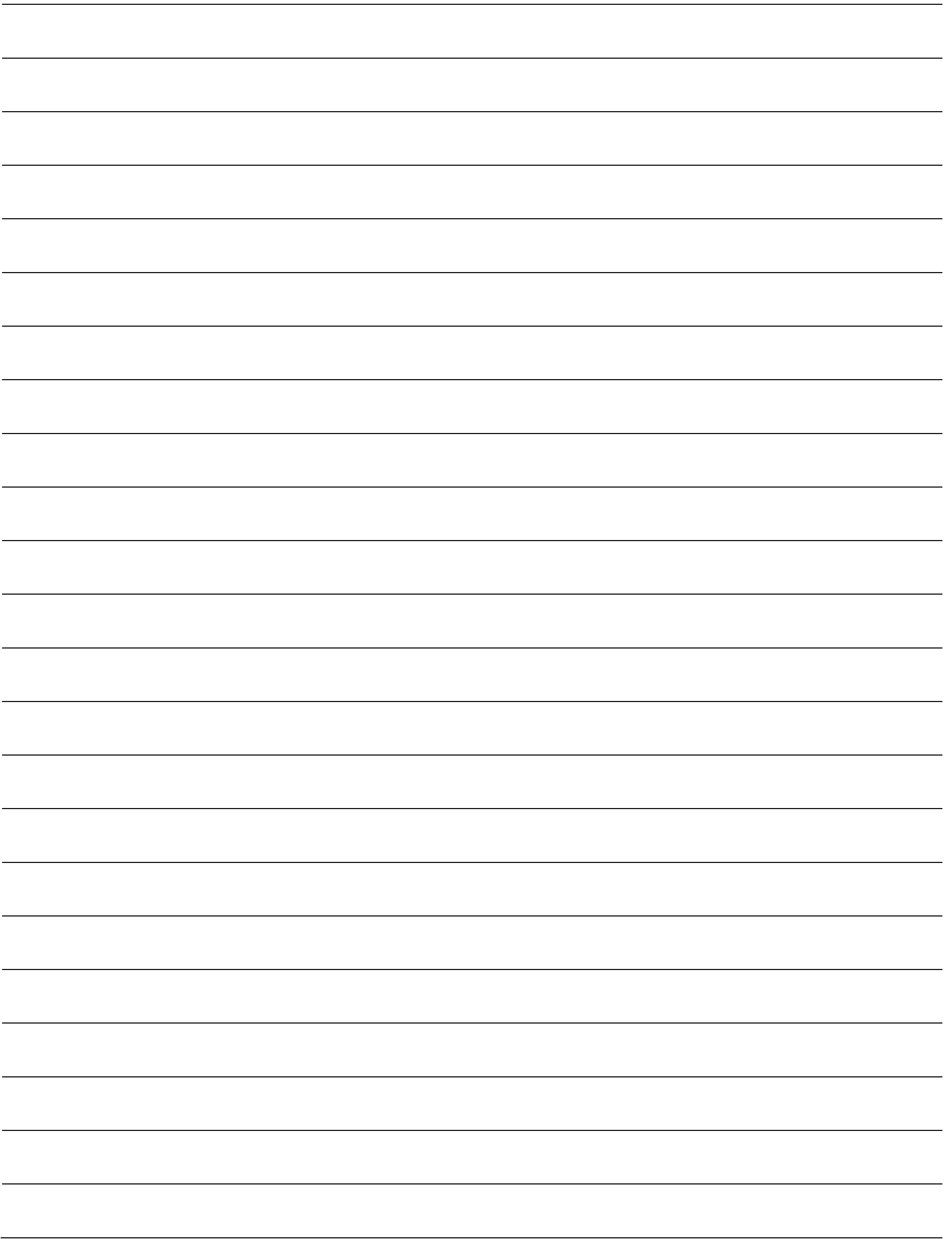

THURSDAY, APRIL 8

1:30 PM – 3:00 PM Rural SIG & Business Meeting

Optional Credit 1.0 CE

Lake Florence

Rural Trauma Centers - Performance Improvement

Donald Jenkins, MD and Carol Immerman, RN, CEN

Session Objectives

1. Explore options for performance improvement and patient safety education to rural referral trauma centers.
2. Discuss examples of action plans for "loop closure" in the rural trauma setting.

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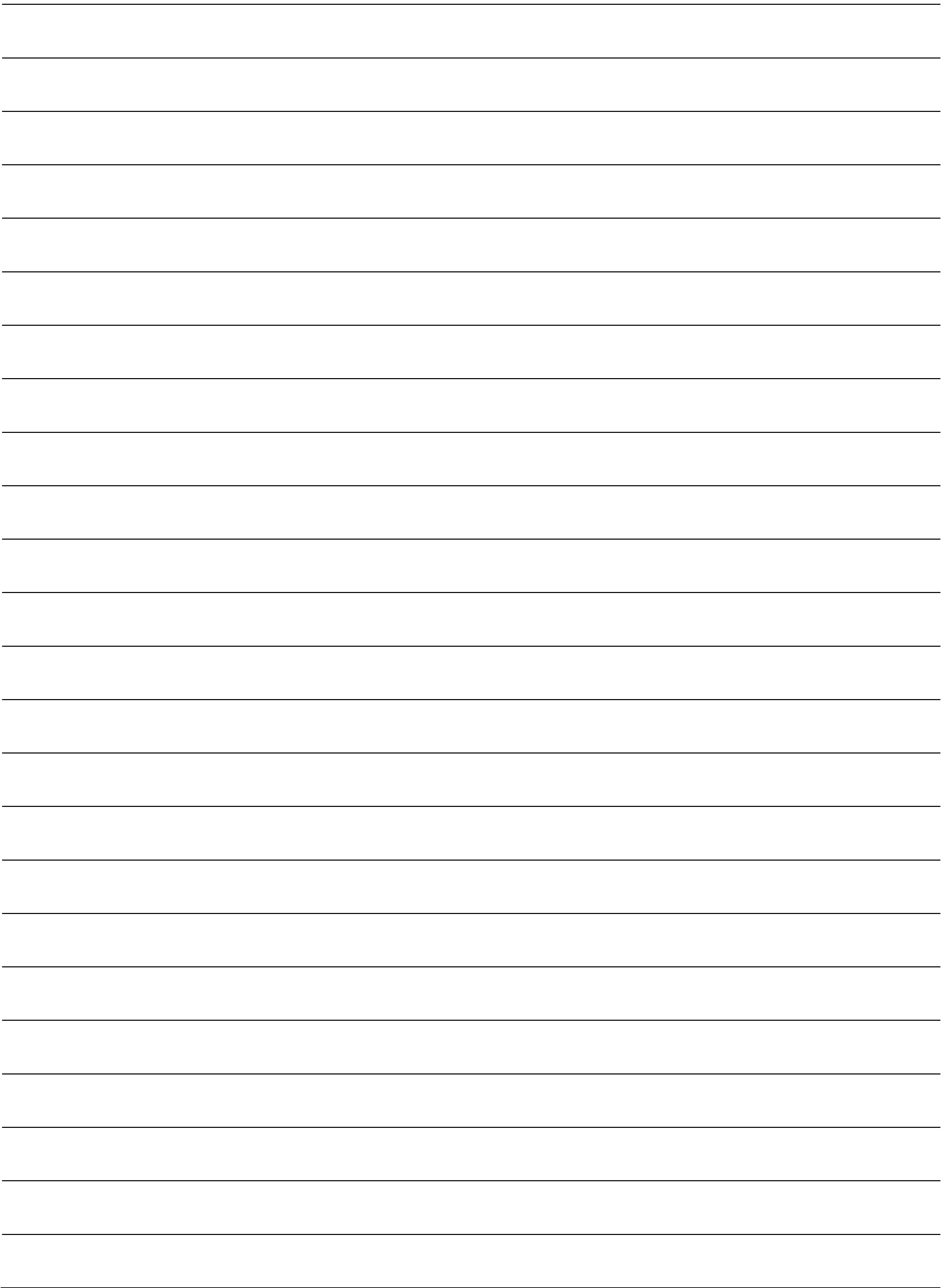

THURSDAY, APRIL 8

1:30 PM – 3:00 PM Education Committee – Chair, Cynthia Blank-Reid, RN, MSN, CEN

Lake Monroe

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1:30 PM – 3:00 PM ATCN Executive Committee – Chair, Michael Glenn, RN

Lake Down

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THURSDAY, APRIL 8

3:00 PM – 4:00 PM **Journal of Trauma Nursing Committee – Editor/Chair, Kathryn Schroeter, PhD, RN, CNOR**
Lake Highland

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3:00 PM – 4:00 PM **Membership Committee - Chair, Melinda Case, RN**
Lake Lucerne

NOTES

THURSDAY, APRIL 8

3:00 PM – 4:00 PM **Pediatric Committee –**
Lake Concord **Co-Chairs, Deb Brown, RN, BSN & Chris McKenna, MSN, RN, CRNP**

NOTES

3:00 PM – 4:00 PM **Disaster Management Committee**
Lake George

NOTES

THURSDAY, APRIL 8

3:00 PM – 4:00 PM Legislation and Public Affairs Committee & SIG

Lake Florence

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3:00 PM – 4:00 PM TOPIC Committee – Chair, Kathleen Martin, RN, MSN, CCRN

Lake Monroe

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THURSDAY, APRIL 8

3:00 PM – 4:00 PM ATCN Open Forum – Chair, Michael Glenn, RN

Lake Down

NOTES

7:00 AM – 8:00 AM The Ideal ACS Verification Site Visit: What would it take?

Orange Ballroom E-G

Moderator – Madonna Walters, MS, RN

For trauma program staff, verification or designation site visits become pivotal events. Countless hours are spent in preparation, to avoid deficiencies during the site visit. But what would it take to have the *ideal* verification site visit? Dr. Tres Mitchell focuses on the positive side of the verification process in this breakfast session, and addresses common concerns about the current criteria for verification, and how to meet or exceed them. This session is open to all who have registered for the full conference.

Session Objectives

1. Examine key elements of the ACS Trauma Verification process.
2. Describe common difficulties encountered by Trauma Programs during verification.
3. Discuss characteristics of the ideal site visit.

Frank "Tres" Mitchell, III, MD, MHA, FACS

St. John Health System, Tulsa, Oklahoma

Dr. Frank "Tres" Mitchell has a long history in the trauma community and is highly visible on the national stage. He has been a member and officer of the National ATLS Committee, a member of the Verification Review Committee of the ACS Committee on Trauma, Region Chief for the Committee on Trauma, and Chairman of the Oklahoma State Committee on Trauma. Dr. Mitchell has been a Verification Review Committee Site Reviewer since 1999 and is the Current Chair of the Committee on Trauma Verification Review Committee. Dr. Mitchell was a site surveyor for the first Trauma Verification Review Committee Site Visit outside the U.S. at Landstuhl Regional Medical Center, Germany. In his role as Chair of the Verification Review Committee, Dr. Mitchell has fostered a collaborative relationship with the Society of Trauma Nurses (STN), which has included support for the new "OPTIMAL" course as well as lecturing at our annual conference for the past three years.

He is the Medical Director, Trauma and Surgical Critical Care at St. John Medical Center in Tulsa, Oklahoma. He has been a general surgeon, trauma surgeon, and director of both trauma and critical care in both Oklahoma and Kansas. Dr. Mitchell graduated with a BA from the University of Missouri, earned his MD from Tulane in New Orleans. He completed his General Surgery Residency at Parkland Memorial in Dallas. He is board certified in General Surgery and in Surgical Critical Care. Dr. Mitchell is a frequent speaker at regional and national conferences. He was also the Course Director for the annual Adult and Pediatric Trauma Symposium for multiple years.

Dr. Mitchell is active in many professional organizations, including the American Society for Bariatric Surgery, the Parkland Surgical Society, the Tulane Surgical Society, and the American Association for Surgery of Trauma, the Society of Critical Care Medicine, Western Trauma Association, and the Society of Law, Medicine & Ethics.

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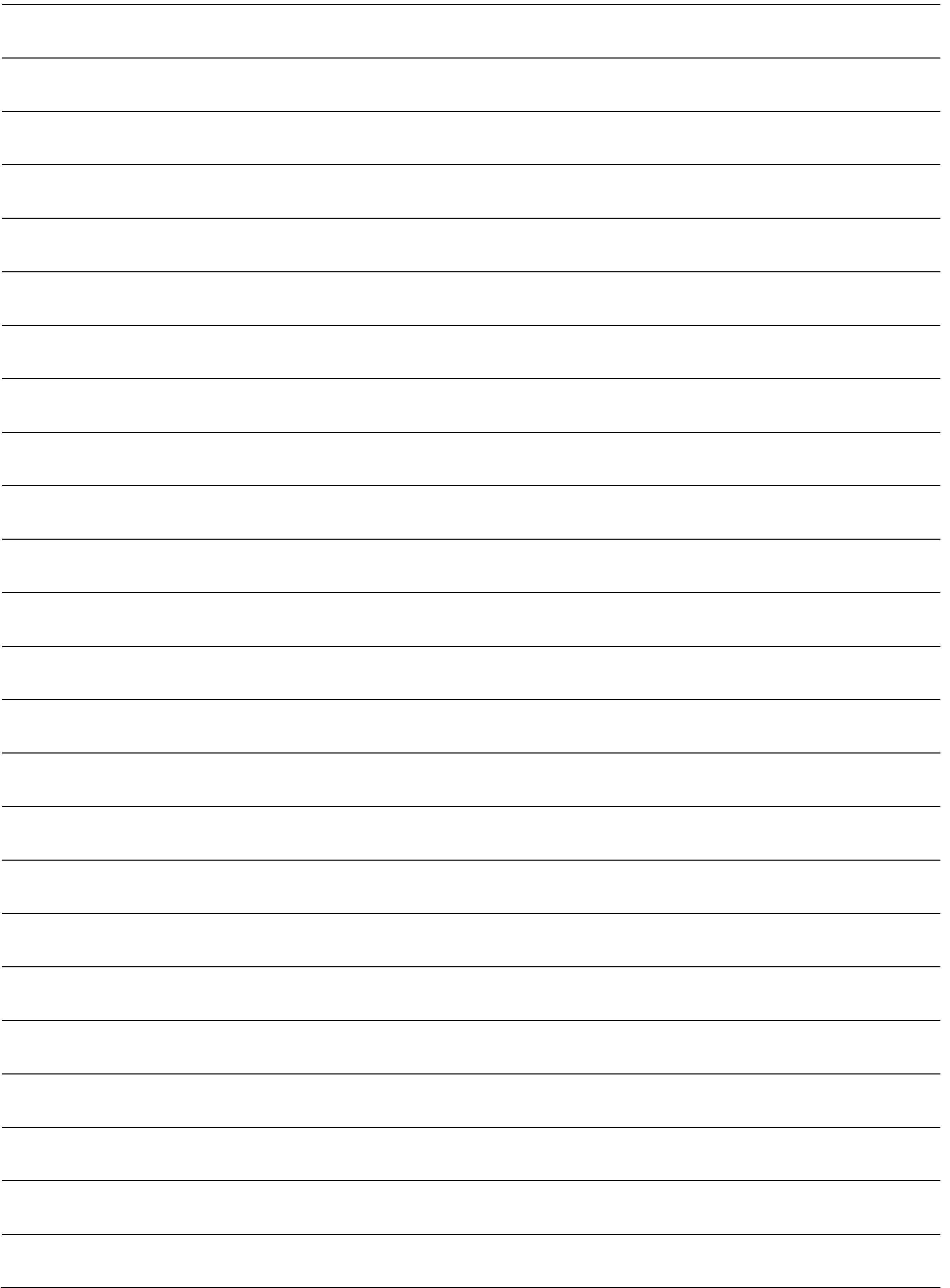

8:05 AM – 9:30 AM Quality & Safety

Orange Ballroom E-G

Moderator – Pat Manion, RN, MS, CCRN, CEN

Monitoring Compliance with Clinical Practice Guidelines

Quality and safety monitoring in trauma includes the evaluation of compliance with clinical practice guidelines. But practice guidelines can be complex and difficult to monitor. Dr. Jenkins offers a practical approach to developing a standardized monitoring plan, which includes both clinical judgment and evidence-based recommendations.

Session Objective: Describe the implementation of a standardized monitoring plan for evaluating compliance with clinical practice guidelines.

Donald Jenkins, MD, FACS

Mayo Clinic, Rochester, Minnesota

President, Eastern Association for the Surgery of Trauma (EAST)

Dr. Donald Jenkins is the current president of the Eastern Association for the Surgery of Trauma (EAST). In 2008, he retired from the U.S. Air Force after having served as the Trauma Medical Director at Lackland Air Force Base in Texas. For over a decade, Dr. Jenkins was responsible for all trauma medical care and administration at Wilford Hall USAF Medical Center in San Antonio, Texas, the USAF's only American College of Surgeons Verified Level I Trauma Center. He was also the Flight Commander and Chairman of General Surgery for 59 MDW (59th Medical Wing – Wilford Hall).

Currently, Dr. Jenkins is a Senior Associate Consultant for the Division of Trauma of Critical Care and Surgery for the Mayo Clinic in Rochester, Minnesota, as well as the Trauma Medical Director and Associate Professor of Surgery in the College of Medicine there. He is also an Assistant Professor of Surgery for the Uniformed Services University in Bethesda, Maryland. He is a nationally recognized speaker and peer-reviewed author, and has published multiple papers on topics that include pulmonary embolism prevention, organ donation and brain death, damage control in an austere environment, resuscitation end-points and tissue oxygenation, substance abuse and withdrawal in the ICU, trauma system development in a theater of war, burn resuscitation guidelines.

Dr. Jenkins received his BS in 1984 at the University of Scranton, Pennsylvania with a major in Biochemistry. He earned his MD in 1988 at the Uniformed Services University in Bethesda, Maryland, and performed his General Surgery Residency at Wilford Hall and Lackland AFB in 1988 and again from 1991-1996. He was a Trauma/Critical Care Fellow at the University of Pennsylvania in 1998. In 1999, Dr. Jenkins received the Diploma Medical Care of Catastrophes from the Society of Apothecaries of London.

Integrating Trauma & Other Quality indicators within a Culture of Safety

Kate FitzPatrick looks beyond the trauma registry, to take a broader look at a variety of hospital quality indicators, core measures, and 'never events.' She challenges us to integrate those within our culture of safety.

Session Objective: Summarize strategies for the creation of an organizational culture of quality and safety in the provision of trauma care.

Kate FitzPatrick, RN, MSN, CRNP-BC

Hospital of the University of Pennsylvania - Philadelphia, Pennsylvania

Kate FitzPatrick is a past President of the Society of Trauma Nurses (2004) and served o n the STN board for 6 years. She continues to serve on the editorial review board for the Journal of Trauma Nursing. She also served three terms on the Board of the Pennsylvania Trauma Systems Foundation. She is currently on the Board of Trustees (Secretary) for the Eastern Association for the Surgery 0f Trauma. She is member of the Pennsylvania State Nurses Association.

Kate has over 23 years of nursing experience involving expertise in the areas of nursing operations, quality/safety, patient flow, rapid response, trauma system development, trauma center development/accreditation and trauma performance improvement. Her clinical background includes pre-hospital, emergency/trauma, and surgical nursing. In addition, she served as the State Trauma System Coordinator for the Division of Public Health in Delaware, which included responsibility for chairing the statewide trauma system development initiative. Kate has held hospital-based leadership positions as the Trauma Performance Improvement Coordinator, Trauma Program Manager, and Trauma Clinical Programs Administrator at the Hospital of the University of Pennsylvania in Philadelphia, a regional resource Level I Trauma Center. Currently, she is Nursing Clinical Director with responsibility for Quality, Safety, and the Unit Based Clinical Leadership model at the Hospital of the University of Pennsylvania.

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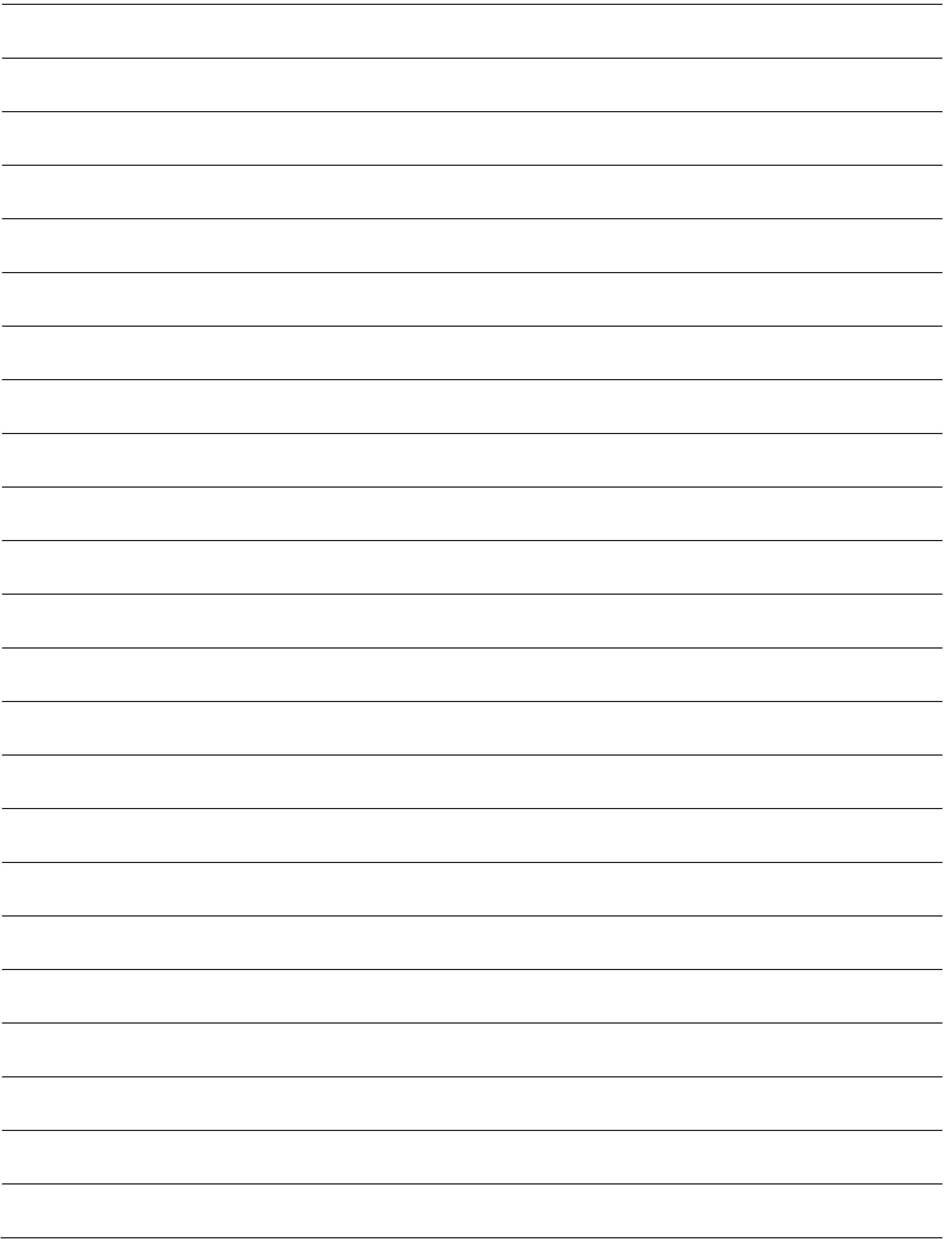


10:05 AM – 11:30 AM Challenging Patients

Orange Ballroom E-G

Moderator – Mike Glenn, RN

Variances in TBI Care Among Civilian and Combat Trauma Victims

Kimberly Meyer uses her experience at the Defense and Veterans Brain Injury Center to examine TBI Care and outcomes among a variety of civilian and military victims. She discusses similarities and differences in injury patterns, triage, and practice in both civilian and combat-related settings.

Session Objective: Summarize the differences between TBI care for civilian versus military victims.

Kimberly Meyer, MSN, ACNP-BC, CNRN

Defense and Veterans Brain Injury Center & Walter Reed Army Medical Center, Washington, DC

Kim Meyer is a Neuroscience Clinician and traumatic brain injury (TBI) specialist with the Defense and Veterans Brain Injury Center, Washington DC. She has over fifteen years of experience with traumatic brain injury management. After earning her BSN from the University of Louisville, she began her career as a staff nurse in a trauma step-down unit, then on to the surgical ICU. Kim subsequently went on to complete her MSN and Acute Care Nurse Practitioner training in 2001 from the University of Kentucky. KIm has worked as a clinical research coordinator and as a neurosurgery nurse practitioner at the University of Louisville, Department of Neurological Surgery. She has served as adjunct faculty at Midway College, where she taught neurotrauma and general neurology topics. Kim now works at the Defense and Veterans Brain Injury Center, which is the operational TBI component of the Defense Center of Excellence. She has been an active member of many nursing organizations, and is currently on the Board of Directors of the American Board of Neuroscience Nurses. KIm lectures widely and has co-authored many peer-reviewed papers on topics including TBI, post-traumatic stress disorder (PTSD) following TBI, spinal cord injury, the promotion of cerebral perfusion, and the management of cerebral edema. Her work has been recognized with certificates of appreciation from the Kentucky Organ Donor Affiliates, the Brain Injury Association of Kentucky, and the Health & Human Services Administration Organ Donation Breakthrough Collaborative.

Ethics and Trauma: Tough Decisions at Difficult Times

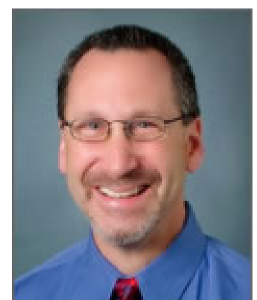
Dr. Vail takes us on a journey of self-examination, with a thought-provoking presentation about the ethical challenges of providing trauma care in the 21st century. This session will help you recognize when the patient has the right to refuse treatment, and to understand how your beliefs affect your ability to perform under challenging circumstances, including the withdrawal of care and the provision of seemingly futile care.

Session Objective

1. Describe patients' rights as they pertain to trauma
2. Differentiate between competency and capacity
3. Explain the difference between lethal and unsalvageable injuries.
4. Recognize the difference in patient management when faced with a mass casualty or disaster scenario.

Sydney J. Vail, MD, FACS

Maricopa Medical Center, Phoenix, Arizona



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11:45 AM – 1:00 PM Distinguished Lectureship: Professional Collaboration to Advance Trauma Care

Orange Ballroom E-G

Moderator – Deb Harkins, RN, BSN, MBA, CCRN – Immediate Past-President, STN

The Society of Trauma Nurses is pleased to announce Dr. Frank "Tres" Mitchell as the recipient of the 2010 Distinguished Lectureship Award. Dr. Mitchell is currently the Medical Director, Trauma and Surgical Critical Care at St. John Medical Center in Tulsa, Oklahoma. He has been a general surgeon, trauma surgeon, and director of both trauma and critical care in both Oklahoma and Kansas.

Dr. Mitchell has a long history in the trauma community and is highly visible on the national stage. He has been a member and officer of the National ATLS Committee, a member of the Verification Review Committee of the ACS Committee on Trauma, Region Chief for the Committee on Trauma, and Chairman of the Oklahoma State Committee on Trauma. Dr. Mitchell has been a Verification Review Committee Site Reviewer since 1999 and is the Current Chair of the Committee on Trauma Verification Review Committee. Dr. Mitchell was a site surveyor for the first Trauma Verification Review Committee Site Visit outside the U.S. at Landstuhl Regional Medical Center, Germany.

In his role as Chair of the Verification Review Committee, Dr. Mitchell has fostered a collaborative relationship with STN, which has included support for the new "OPTIMAL" course as well as lecturing at our annual conference for the past three years.

Session Objectives

1. Discuss the evolution of trauma performance improvement and patient safety
2. Describe the positive effects of professional collaboration in trauma care between trauma nurses and trauma surgeons.

Frank "Tres" Mitchell, III, MD, MHA, FACS

St. John Health System, Tulsa, Oklahoma

Dr. Frank "Tres" Mitchell has a long history in the trauma community and is highly visible on the national stage. He has been a member and officer of the National ATLS Committee, a member of the Verification Review Committee of the ACS Committee on Trauma, Region Chief for the Committee on Trauma, and Chairman of the Oklahoma State Committee on Trauma. Dr. Mitchell has been a Verification Review Committee Site Reviewer since 1999 and is the Current Chair of the Committee on Trauma Verification Review Committee. Dr. Mitchell was a site surveyor for the first Trauma Verification Review Committee Site Visit outside the U.S. at Landstuhl Regional Medical Center, Germany. In his role as Chair of the Verification Review Committee, Dr. Mitchell has fostered a collaborative relationship with the Society of Trauma Nurses (STN), which has included support for the new "OPTIMAL" course as well as lecturing at our annual conference for the past three years.

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1:30 PM – 3:15 PM Resuscitation

Orange Ballroom E-G

Moderator – Vicki Bennett, RN, MSN, CEN, CCRN

Is successful trauma resuscitation more than the sum of its parts? Trauma nurses know that it is. Resuscitation requires not only the right fluids and tests, but also critical thinking skills and the ability to process information quickly. During this plenary session, three experts take you beyond the basics to discuss the finer points of resuscitation, including an appraisal of the role of the nurse and a review of the controversy surrounding hemoglobin targets.

Role of the Nurse in Trauma Resuscitation

Session Objectives:

1. Describe the nurse's role in trauma resuscitation
2. Discuss assessment and management priorities that optimize trauma resuscitation.

Michele Ziglar, MSN, RN

Shands at the University of Florida, Gainesville, Florida

Michele Ziglar has dedicated her past 20 years of nursing to trauma program development and research. She is currently the Director of Trauma & Aeromedical Services at Shands at the University of Florida in Gainesville. She has been active in many professional organizations, including the Society of Trauma Nurses (STN), the Emergency Nurses Association (ENA), the American Trauma Society (ATS), and in regional and state trauma organizations. She is the current president of the Association of Florida Trauma Coordinators (AFTC) and Vice-President of the North Central Florida Trauma Agency (NCFTA). She is a previous board member and Education Committee Chair of STN. She is also a consultant/ site surveyor for the Pennsylvania Trauma Systems Foundation and the Colorado Department of Public Health and Environment.

Michele received her MSN in administration from the University of North Carolina at Greensboro. She has been the recipient of multiple awards, including an Annual Student Research Award and an MSN Student Excellence Award, both from Sigma Theta Tau International (Gamma Zeta Chapter). She has also received service and recognition awards from the ENA, STN, and ATS. Her busy career has spanned many roles, including bedside staff nurse, EMS and trauma educator and coordinator, regional trauma coordinator, trauma program manager and director, and trauma unit nurse manager. Throughout her career, she has presented at many national conferences.

She has coordinated many research and project grants, and has co-authored multiple publications in the care of trauma patients. Her areas of research interest include inter-hospital trauma transfers, telemedicine, hospital preparedness and mass casualty training, ICU surge capacity, burn training, hemorrhagic shock, resuscitation, the evaluation of cervical spine injuries, care of the obese trauma patient, and clinical decision making.

Hemoglobin Targets – Where's the Evidence

Session Objective: Summarize current research on the subject of transfusion thresholds and hemoglobin targets.

Judy Mikhail, RN, MSN, MBA

Hurley Medical Center, Flint, Michigan

Judy Mikhail has over 30 years of progressive trauma nursing experience, most recently as the administrator for Trauma, Bariatrics, and Neuroservices at Hurley Medical Center, a Level-1 Trauma in Flint, Michigan. She began her nursing career in the Burn Unit at Hurley, and progressed from surgical ICU staff nurse to clinical nurse specialist and ultimately a trauma program manager and trauma administrator. Judy earned her diploma in nursing from Hurley Medical Center School of Nursing, her BSN from the University of Michigan, and MSN from the University of Texas. In 2003, she completed work on her MBA from Colorado State University. Judy is currently a full-time doctoral nursing student at the Medical University of South Carolina. She has been active in many professional organizations, including the Eastern Association for the Surgery of Trauma (EAST), the American Burn Association (ABA), the American Organization of Nurse Executives (AONE), the Emergency Nurses Association (ENA), the American Association of Critical Care Nurses (AACN), and the Society of Trauma Nurses (STN)

Judy is a nationally recognized speaker in trauma care and an active educator and course director for PreHospital Trauma Life Support (PHTLS), Advanced Trauma Life Support (ATLS), Advanced Trauma Care for Nurses (ATCN), the Trauma Nurse Core Course (TNCC), the Course in Advanced Trauma Nursing (CATN), Fundamental Critical Care Support (FCCS), and Advanced Cardiac Life Support (ACLS). She serves as an adjunct instructor for the University of Michigan-Flint, School of Nursing. Judy has authored over 18 publications in trauma, including the evaluation and treatment of abdominal trauma, the use of midlevel providers in trauma centers, injury severity scoring, resuscitation endpoints in trauma, and care of the burn patient. She has won three local research awards. She has served as President and Treasurer of the board of directors of STN. Judy has been involved in trauma system development in Michigan, including serving as President of the Michigan Trauma Coalition, and she currently serves on the State of Michigan Trauma Advisory Committee.

Trauma Resuscitation: The Finer Points

Session Objective: Provide examples of advanced trauma management that should be used in trauma resuscitation.

Donald Jenkins, MD, FACS

Mayo Clinic, Rochester, Minnesota
President, Eastern Association for the Surgery of Trauma (EAST)

Dr. Donald Jenkins is the current president of the Eastern Association for the Surgery of Trauma (EAST). In 2008, he retired from the U.S. Air Force after having served as the Trauma Medical Director at Lackland Air Force Base in Texas. For over a decade, Dr. Jenkins was responsible for all trauma medical care and administration at Wilford Hall USAF Medical Center in San Antonio, Texas, the USAF's only American College of Surgeons Verified Level 1 Trauma Center. He was also the Flight Commander and Chairman of General Surgery for 59 MDW (59th Medical Wing – Wilford Hall).

Currently, Dr. Jenkins is a Senior Associate Consultant for the Division of Trauma of Critical Care and Surgery for the Mayo Clinic in Rochester, Minnesota, as well as the Trauma Medical Director and Associate Professor of Surgery in the College of Medicine there. He is also an Assistant Professor of Surgery for the Uniformed Services University in Bethesda, Maryland. He is a nationally recognized speaker and peer-reviewed author, and has published multiple papers on topics that include pulmonary embolism prevention, organ donation and brain death, damage control in an austere environment, resuscitation end-points and tissue oxygenation, substance abuse and withdrawal in the ICU, trauma system development in a theater of war, burn resuscitation guidelines.

Dr. Jenkins received his BS in 1984 at the University of Scranton, Pennsylvania with a major in Biochemistry. He earned his MD in 1988 at the Uniformed Services University in Bethesda, Maryland, and performed his General Surgery Residency at Wilford Hall and Lackland AFB in 1988 and again from 1991-1996. He was a Trauma/Critical Care Fellow at the University of Pennsylvania in 1998. In 1999, Dr. Jenkins received the Diploma Medical Care of Catastrophes from the Society of Apothecaries of London.

NOTES

3:30 PM – 4:30 PM RAPID FIRE – Special Populations

Orange Ballroom E-G

Moderator – Sue Cox RN, MS, CEN, PHN – STN President

We wrap up our conference with a discussion of three special populations, defined by their age, culture, mechanism of injury, and vulnerability. Pat Manion shares her experience participating in the development of a fall prevention clinic for older adults, which produced measurable results and revenue for their trauma center. Sue Rzucidlo helps us understand injury patterns among those who may live "off the grid" by examining the spectrum of injury seen among the Amish. And, Karen Macauley attempts to answer an important question about the ability of adult trauma centers to make the difficult diagnosis of child abuse.

Fall Prevention Clinics for Seniors: Cost-effective Programs that Work

Session Objective: Evaluate the cost-benefit of fall-prevention clinics for older adults

Pat Manion, RN, MS, CCRN, CEN

Grand Blanc, Michigan

Pat Manion has over 13 years of experience in trauma program management, most recently as the trauma program director at Genesys Regional Medical Center in Grand Blanc, Michigan. She has worked in critical care and trauma education, orthopedic case management, cardiac surgery program development, direct patient care in critical care and trauma, and trauma program development. Pat has been very active in the Society of Trauma Nurses (STN) for the past 10 years, and is currently the Secretary on the STN Board of Directors. She also served as the STN Conference Chairperson from 2006 through 2009. She is very active in the Emergency Nurses Association, serving as State officer and State Faculty for TNCC. Pat has spoken extensively in the State of Michigan and nationally on critical care and trauma topics. She has many publications to her name, and has been a subject matter reviewer/ editor for Principles of Basic Trauma Nursing (2nd Edition, 2006, Western Schools, Inc.) and the Trauma Nursing Core Curriculum (TNCC) textbook (6th Edition revision, 2007). Her areas of particular expertise are geriatric trauma, complications of trauma, trauma case studies, and injury prevention for the elderly population. She has mentored many other prospective trauma centers as they worked toward successful ACS trauma center verification.

How Culture Affects Injury Patterns – A look at the Amish

Session Objective: List three common types of injury in Amish communities.

Susan Rzucidlo, MSN, RN

Penn State Hershey, Hershey, Pennsylvania

For the past 15 years, Susan Rzucidlo has been the pediatric trauma and injury prevention program manager at the Level I pediatric trauma program at Penn State Hershey Children's Hospital, Milton S. Hershey Medical Center. She is responsible for the administrative and clinical oversight for trauma designation. Susan is the coordinator of Safe Kids Dauphin County and manages the staff and resources for the campus injury prevention initiatives. She is a certified child passenger safety instructor, STN pediatric committee member and Think First chapter coordinator.
Susan received a Bachelor of Science in Nursing from the University of Pittsburgh. She completed a Master's of Science in Nursing from Duquesne University in Education and Trauma / Critical Care nursing. She has many years of experience both as a staff nurse in the pediatric ICU and in staff education as a staff development instructor, education coordinator, and program manager in training and development. She has co-authored multiple papers and her research interests include parental knowledge about infant car seats, child abuse, pediatric blunt pancreatic injury, traumatic stress symptoms, pediatric trauma in the Amish community, and preventing head injuries in children. She is a frequent speaker at local, regional, and national meetings.

Is Child Abuse Being Missed at Adult Trauma Centers?

Session Objective: Compare current child-abuse screening and detection rates at adult and pediatric trauma centers.

Karen Macauley, RN, MEd

All Children's Hospital, St Petersburg, Florida

Karen Macauley has worked with trauma patients for the last 20 years, and is currently the trauma program manager at a free-standing children's hospital, the All-Children's Hospital in St. Petersburg, Florida. She received both her BSN and Masters in Health Education from Pennsylvania State University. Karen is currently enrolled in a Doctor of Health Administration program through the University of Phoenix. She is an active member of the Society of Trauma Nurses (STN) as a current STN board member and EAST Committee member. She has also been active in the Trauma Nurse Council of the American Trauma Society (ATS). Karen currently serves on the Florida Injury Prevention Advisory Council and the Florida Trauma Strategic Plan Advisory Council. She is also a Washington State trauma site surveyor.

Karen is active in injury prevention as a THINK FIRST presenter and as a certified Child Passenger Safety (CPS) technician and Instructor. She has coordinated multiple injury prevention grants and clinical research projects. Karen has lectured extensively on a variety of trauma topics, including burn care, child abuse, alcoholism and trauma, spinal cord injury, and as faculty for the ATS' Trauma Coordinator's Course.

NOTES

4:30 PM **Closing Remarks**

Orange Ballroom E-G

Susan A. Cox, RN, MS, CEN, PHN
STN President & Rady Children's Hospital and Health Center San Diego, California

NOTES

EXHIBIT HALL INFORMATION

Educational Sessions – Thursday, April 8, 2010

For the first time this year, four (4) exhibitors are offering continuing education (CE) content at their booths. These breakout sessions will collectively comprise of a session called **TRAUMA MANAGEMENT UPDATES**. Individual breakouts will be short – 17 minutes including Q&A – and nurses must attend at least three (3) of the sessions to earn one (1) CE contact hour.

Exhibitor CE participants include:

- ACS: NTDB/TQIP – *Booth 101*
- Aspen Medical Products – *Booth 401*
- Hutchinson Technologies – *Booth 301*
- Ossur Americas – *Booth 201*

Exhibit Hall Hours

Thursday, April 8, 2010 – Full Conference Sessions

11:00 AM	–	6:30 PM	**Exhibit Hall Open**	*ORANGE A-D*
11:30 AM	–	1:15 PM	**Lunch in the Exhibit Hall – Poster Viewing**	*ORANGE A-D*
4:00 PM	–	6:30 PM	**Brain Teasers & Palate Pleasers - Welcome Reception, Poster Judging & Exhibitor Sponsored CE sessions**	*ORANGE A-D*

Friday, April 9, 2010 Full Conference Sessions

9:30 AM	–	10:00 AM	**Break - Exhibit Hall Open**	*ORANGE A-D*
1:00 PM	–	1:30 PM	**Poster Viewing & Networking – Exhibit Hall Open**	*ORANGE A-D*
2:00 PM	–	5:00PM	**Exhibit Tear-Down**	*ORANGE A-D*

Treasure Hunt

ARR!!! Grab a mate, lass or scallywag and start searching for the booty!!! Follow the clues provided in your registration packet to the treasure chest! The exhibitors are ready and waiting to help you navigate the way. After completing the hunt, drop your map in the treasure chest by **10:00 AM on Friday, April 9, 2010**. Winners will be announced during the break in the exhibit hall at **1:00 PM on Friday, April 9, 2010**! Prizes include free STN memberships, complimentary 2011 conference registrations, overnight hotel stays, sterling silver jewelry, educational materials/products and much more….

Don't get caught hornswaggling or you'll have to walk the plank!!!

EXHIBITOR BOOTH ASSIGNMENTS

TRAUMA MANAGEMENT UPDATES – EXHIBITOR-SPONSORED CE

America College of Surgeons: NTDB/TQIP	**101**
Aspen Medical Products	**401**
Hutchinson Technology	**301**
Ossur Americas	**201**

Arizant Healthcare, Inc	109
Astellas	403
Baylor Health Care System	402
Board of Certification for Emergency Nursing (BCEN)	203
CARES/Omnicell	105
Clinical Data Management	405
Digital Innovations	205
Harris County Hospital District	104
Hospira	208
I-Flow Corporation-A Kimberly Clark Health Care Company	304
I'm Safe – Child Safety Solutions	305
Irrimax Corporation	209
Lancet Technology, Inc	103
Lippincott, Williams & Wilkins – Wolter Kluwer Health	106
Masimo	100
NeurOptics	404
Orlando Health	204
Simulab Corporation	504
Society of Trauma Nurses	503
Tampa General Hospital	102
US Army Health Care Recruiting	302
Vidacare	303
Wolfe Tory Medical	202
Z-Medica Corporation	502
Zoll Medical	308

SOCIETY OF TRAUMA NURSES
APRIL 8-9, 2010

EXHIBITOR	#
TRAUMA MANAGEMENT UPDATES	
America College of Surgeons: NTDB/TQIP	**101**
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Harris County Hospital District	104
Hospira	208

D

FOOD & BEVERAGE AREA

10' 10' 10' 10' 10'

109 208 209 308

106 104 102 100

105 204 103 202 16' 101

205 304 203 302 16' 201

305 404 303 402 16' 301

405 504 403 502 16' 401

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ENTRANCE

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EXHIBITOR	#
I-Flow Corporation	304
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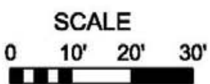

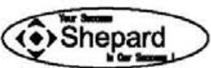

– FIRE STROBE; CH 12'

FE – FIRE EXTINGUISHER

Inventory as of 03/09/2010

Dimension	Size	Qty	SqFt
10'x16'	160	4	640
8'x10'	80	30	2,400
	Totals:	34	3,040

ORANGE BALLROOM A-D
HILTON ORLANDO

Optional Credit

American College of Surgeons: National Trauma Data Bank and Trauma Quality Improvement Program – Booth 101

Julia McMurray, NTDB Coordinator
American College of Surgeons
633 N. Saint Clair St.
Chicago, IL 60611
312-202-5511
312-202-5015
jmcmurray@facs.org
www.ntdb.org

The NTDB contains detailed trauma data on nearly four million cases from over 900 U.S. trauma centers. The data have been shared with hundreds of researchers, and numerous articles have been published based upon the NTDB. The annual NTDB Call for Data (CFD) runs from March to May and all hospitals with trauma registries are encouraged to participate. After the conclusion of the CFD, the data are cleaned and summarized in the NTDB Annual Report distributed in September. The National Trauma Data Bank has adopted the National Trauma Data Standard (NTDS) as the basis for data collection. The NTDS is a standardized definition of the trauma injury information submitted to the NTDB by participating hospitals (see www.ntdsdictionary.org). The Trauma Quality Improvement Program (TQIP) provides risk adjusted benchmarking to participating NTDB hospitals, and provides a means for comparison across centers and sharing of best practices with the goal of improving care for injured patients.

Using Trauma Benchmark Data in QI & Research

Michelle D. Pomphrey, MLT, RN, CSTR

Session Objective: Appraise the value of national benchmarking for the evaluation of trauma registry data.

NOTES

Aspen MEDICAL PRODUCTS INC.

Optional Credit

Aspen Medical Products – Booth 401

Francie Hill
Marketing Communications Specialist
6481 Oak Canyon
Irvine, CA 92618
949-681-0200
949-681-0300
fhill@aspenmp.com
www.aspenmp.com

Aspen Medical Products is a leader in the development of innovative spinal bracing for post-trauma stabilization, pre-and-post surgical stabilization, pain management and long-term patient care. Aspen Medical Products offers multiple orthotic options that provide unsurpassed motion restriction, superior comfort and an economic advantage, encouraging better patient compliance.

Cervical Collar Application and Use

Deanna Wolfe, RN, BSN

Session Objectives:

1. Describe appropriate cervical collar application.
2. Discuss helpful hints and pearls for maintaining patients in cervical collars without complications
3. Provide hands on experience in collar application technique

NOTES

Optional Credit

Hutchinson Technology, Inc – Booth 301

Kathy Whalen, Marketing Services
Assistant
40 West Highland Park Drive NE
Hutchinson, MN 55350
320-587-1770
320-587-1555
biom.usa@hti.htch.com
www.htibiomeasurement.com

The non-invasive **InSpectra**™ StO_2 Tissue Oxygenation Monitor provides continuous, real-time information for perfusion status monitoring; a new hemodynamic parameter that assists clinicians in the early detection of inadequate tissue perfusion (hypoperfusion). The **InSpectra** StO_2 System provides value to clinicians by allowing them to track patient response (regardless of the cause of hypoperfusion (e.g. hypovolemia, early sepsis, cardiogenic shock) to interventions in real-time, assisting with fluid management.

Putting First Things First During Trauma Resuscitation: Is the Patient Perfusing?

Christine Schulman, RN MS, CNS, CCRN

Session Objectives:

1. Discuss how serum lactate, base deficit, and tissue oxygen saturation reflect tissue perfusion
2. Discuss challenges of chemical markers to assess resuscitation status.
3. Determine resuscitation status and plan appropriate interventions using serum lactate, base deficit, tissue oxygen saturation, and other hemodynamic parameter

NOTES

EXHIBITOR COMPANY INFORMATION – TRAUMA MANAGEMENT UPDATES

ÖSSUR ®

Optional Credit

Ossur Americas – Trauma & Spine – Booth 201

Steven Kamm
Product Marketing Manager
19762 Pauling
Foothill Ranch, CA 92610
skamm@ossur.com
www.ossur.com

Össur is a leader in Spinal Solutions. Our industry leading brands, Miami J®, Resolve® Halo, Occian™ Back and the *NEW* Miami Lumbar™ LSO help to provide successful outcomes for you and your patients.

Cervical Spine Precautions & Immobilization Update

Katie Swanson, BS,CHES

Session Objectives:

1. Discuss how to determine the appropriate size when applying a cervical collar.
2. Discuss challenges of chemical markers to assess resuscitation status.
3. Describe how to customize and fine tune the fit of collar on the patient
4. Perform appropriate skin care on a collared patient.

NOTES

EXHIBITOR COMPANY INFORMATION

Arizant Healthcare – Booth 109

10393 W. 70th Street
Eden Prairie, MN 55344
1-800-733-7775
1-800-775-0002
cs@arizant.com
www.arizanthealthcare.com

Arizant Healthcare Inc. pioneered forced-air warming technology with the introduction of the Bair Hugger® therapy in 1987. With the introduction of the Ranger® blood/fluid warming system and, most recently, the Bair Paws® patient adjustable warming system, our products have been used to maintain normothermia for over 100 million patients worldwide

Baylor Health Care System – Booth 402

Tracy Fletcher, Recruitment Specialist
2001 Bryan Street, Suite 600
Dallas, TX 75201
214-820-6964
214-818-6221
tracyf@baylorhealth.edu
www.baylorhealth.edu/careers

Nationally recognized as a leader in health care, Baylor Health Care System, located in Dallas/Fort Worth, offers limitless career opportunities. Our 15 hospitals and over 100 clinics allow mobility between environments and specialties. Wherever you want your career and life to take you, we'll help you get there.

Astellas Pharma US, Inc – Booth 403

Diane Killian
Exhibit Consultant
Three Parkway North
Deerfield, IL 60015
800-888-7704
847-317-5953
www.astellas.com/us

Astellas Pharma US, Inc. is a research-based pharmaceutical company dedicated to improving the health of people around the world through innovative pharmaceutical products. For more information on Astellas, please go to www.us.astellas.com

Board of Certification for Emergency Nursing – Booth 203

Customer Service Team
915 Lee Street
Des Plaines, IL 60016
847-460-2630
847-460-2631
BCEN@ena.org
www.ena.org/bcen

BCEN is the organization responsible for certifying more than 20,000 emergency, flight and critical care ground transport nurses worldwide. Since January 2009 BCEN (in partnership with PNCB) offers the Certified Pediatric Emergency Nurse (CPEN™) certification.

Stop by the booth to obtain information regarding the Certified Emergency Nurse (CEN®), Certified Flight Registered Nurse (CFRN®), Certified Transport Registered Nurse (CTRN®), and the Certified Pediatric Emergency Nurse (CPEN™) certification.

EXHIBITOR COMPANY INFORMATION

CARES/Omnicell – Booth 105

Kevin Burroughs
System Sales Director – Omnicell Vendor Solutions
1201 Charleston Rd
Mountain View, CA 94043
804-519-2548
804-777-9538
kevin.burroughs@omnicell.com
www.thecareswebsite.com

Critical and Rehabilitative Equipment Solutions (CARES) provides orthopedic soft goods outsourcing solutions to hospitals that do not have a Durable Medical Equipment (DME) License. The lack of this license prohibits the hospital from billing Medicare Part B and other payors (HMO, PPO or Medicare replacement) for the items they provide their patients and this service becomes an overhead expense. CARES, being a subsidiary of Hanger Orthopedic group, accesses their DME License and over 3800 insurance contract, some of which are national exclusive relationships.

Clinical Data Management – Booth 405

Dana Loomis, Sales and Marketing Director
P. O. Box 279
Conifer, CO 80433-0279
303-670-3331 ext. 4
303-670-3394
dana@c-d-m.com
www.c-d-m.com

Clinical Data Management (CDM), developers of TraumaBase trauma registry systems, has been providing data collection applications for hospitals and government entities in the US and overseas for over 25 years. This experienced involvement in the trauma field has allowed CDM to evolve both as a software provider and capable trauma advocate. CDM sets the standard with exceptionally powerful and flexible software, designed with the perspective of Emergency Department clinicians and expert software developers with diligent attention to data integrity for trauma programs dedicated to performance improvement and trauma prevention and research.

Digital Innovation, Inc – Booth 205

Julie Violante, Director of Professional Services
134 Industry Lane, Suite 3
Forest Hill, MD 21050
410-838-4034, ext 255
410-893-3199
jviolante@dicorp.com
www.dicorp.com

Digital Innovation, Inc. is the industry leader in the design, development and support of trauma registry systems. Our Windows and Web software applications for trauma, outcomes tracking, medical research and NEMSIS Gold Compliant EMS linkage are running at more than 1,400 facilities worldwide, supporting the registry needs of states, provinces, regions, and individual facilities.

Harris County
Hospital District

Harris County Hospital District – Booth 104

Renee Banks, Professional Nurse Recruiter
Harris County Hospital District – Human Resources
5656 Kelley Street, UT Annex – Ste 271
Houston, TX 77026
713-566-8580
713-566-4251
renee_banks@hchd.tmc.edu
www.hchdonline.com

The Harris County Hospital District in Houston, Texas, is the public healthcare system for the nation's third most-populous county. It provides quality healthcare for more than 1.4 million patient visits each year to residents of Harris County. It operates Ben Taub General Hospital, Lyndon B. Johnson General Hospital, Quentin Mease Community Hospital, 13 community health centers, a dental center, a dialysis center, eight school-based clinics, 13 homeless shelter clinics and five mobile health units.

Hospira – Booth 208

Brando Derrick, ACCS District Manager, Florida
3050 Stanfield Ave
Orlando, FL 32814
224-422-9278
847-574-0361
Brandon.derrick@hospira.com
www.hospira.com

Hospira is a global specialty pharmaceutical and medication delivery company driven by its vision of Advancing Wellness™. Bringing proven leadership and experience, Hospira provides solutions to help improve the productivity, safety and effectiveness of patient care.

I-Flow Corporation-A Kimberly Clark Health Care Company – Booth 304

Scott Lohse, Sr Marketing Coordinator
20202 Windrow Drive
Lake Forest, CA 92630
949-206-2700
303-670-339949-206-2600
scottlohse@iflo.com
www.iflo.com

The ON-Q® Post-Op Pain Relief System provides automatic and continuous infusion of a local anesthetic to the patient's surgical site area or adjacent nerves immediately following surgery, getting patients back on their feet faster. It reduces patients' need for narcotics and decreases potential of breakthrough pain. Also, simple, yet elegant and requires little to no management or intervention by the patient or caregiver. The device is completely portable and can be carried in a pouch or attached to a patients' clothing. To learn more about the benefits of ON-Q visit www.AskYourSurgeon.com.

I'm Safe – Child Safety Solutions – Booth 305

Alison Contento
PO Box 1403
Rockland, ME 04840
877-669-7233, ext 205
207-226-3873
Alison@imsafe.com
www.imsafe.com

Child Safety Solutions, Inc. creates multilingual educational materials tailored to specific communities as well as national campaigns. We work cooperatively with individuals, agencies, businesses and communities, both nationally and internationally, in multiple languages, to:

- protect children from preventable injuries
- predator-proof our youth
- provide innovative, community-centered injury-prevention programs using a variety of media

We offer tremendous flexibility, superior service, and a fun, accurate educational approach. Our materials have been effectively used by state departments of transportation and health, corporations, hospitals, schools and agencies across the U.S. and in Canada. Please call us at 877-669-7233 Ext. 205 to discuss how we can support your community outreach efforts.

Irrimax Corporation – Booth 209

Helen Thompson, Sales and Marketing Administer
1665 Lakes Parkway, Suite 102
Lawrenceville, GA 30043
770-807-7223, ext 1601
helent@irrimax.com
www.irrimax.com

Fast. Effective. Safe - A new standard for wound irrigation.

- Compressible bottle irrigation for field, clean and sterile settings
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- Approved for military use

EXHIBITOR COMPANY INFORMATION

Lancet Technology, Inc – Booth 103

Leon M. Bowman, Sales
123 South Street, 3rd Floor
Boston, MA 02111
800-2-LANCET
617-542-4343
info@lancettechnology.com
www.lancettechnology.com

Lancet Technology, Inc. has been providing powerful and flexible information solutions to the emergency and trauma communities for over 20 years. Our suite of products - Trauma One, Fire-Rescue One, and Lancet One provides feature-rich solutions to your informational needs regardless of the size of your institution. Our products are at home in large state-wide systems as well as single-site systems at large trauma centers and small rural hospitals. Our solutions provide flexible efficient data capture and a very robust easy-to-use report writer. Ease of use, compliant with national standards, fully customizable, and excellent customer service are features that highlight our solutions.

Masimo – Booth 100

Karen Pham, Tradeshow Coordinator
40 Parker
Irvine, CA 92618
949-297-7534
801-315-4140
kpham@masimo.com
www.masimo.com

Masimo is a global medical technology company that develops and manufactures innovative noninvasive monitoring technologies, including medical devices and a wide array of sensors that may enable earlier detection and treatment of potentially life-threatening conditions. A key medical technology innovator, Masimo is responsible for the invention of award-winning noninvasive technologies that are revolutionizing patient monitoring, including Masimo SET® pulse oximetry, Masimo Rainbow SET® noninvasive and continuous total hemoglobin (SpHb™), acoustic respiration rate (RRa™), and Masimo Patient SafetyNet™.

Lippincott, Williams & Wilkins – Booth 106

Kathleen Phelan, Publisher
Two Commerce Square
Philadelphia, PA 19103
215-521-8300
kathleen.phelan@wolterskluwer.com
www.lww.com

Lippincott Williams & Wilkins, a Wolters Kluwer Health company is a leading publisher of medical, health, and science publications, including ***Journal of Trauma Nursing***. We proudly offer an extensive selection of medical books, journals, and electronic media for physicians, nurses, students and clinicians. Please visit booth #106 to browse our comprehensive product line.

Neuroptics – Booth 404

Deborah Fineberger, VP of Marketing
17811 Sky Park Circle, Ste. H
Irvine, CA 92614
949-250-9792
949-250-9796
info@neuroptics.com
www.NeurOptics.com

The NeurOptics® NPi™-100 Pupillometer is a hand-held, cordless and simple to use device which removes subjectivity from the measurement of the pupillary light response. Now even the smallest changes in pupillary function which are not discernable to the naked eye are detectable by clinicians and can be measured and quantified.

EXHIBITOR COMPANY INFORMATION

Orlando Health – Booth 204

Dorothy Latkowski, Recruiter
85 West Gore St
Orlando, FL 328061
321-841-1601
321-841-7011
Dorothy.latkowski@orlandohealth.com
www.orlandohealth.com

Orlando Health is one of Florida's most comprehensive private, not-for-profit healthcare networks. With world-class facilities, advanced medical treatments and procedures featuring the area's only Level 1 Trauma Center and Level 1 Pediatric Trauma Center, community based hospitals, a hospital for women and babies, and a cancer center we have a solid foundation upon which you can build your profession. orlandohealth.com

Society of Trauma Nurses – Booth 503

Sarah Clements, Executive Director
1020 Monarch St, Ste 300B
Lexington, KY 40513
859-977-7456
859-977-7441
sclements@traumanurses.org
www.traumanurses.org

The Society of Trauma Nurses is the leading professional organization which promotes the advancement of trauma nursing, trauma education, and the development of nursing leadership at the national and international levels. The Society of Trauma Nurses envisions a health system in which trauma nurses work collaboratively to comprehensively impact trauma care delivery throughout the world.

Simulab Corporation – Booth 504

Dave Garland, Vice President of Sales
1600 W. Armory Way
Seattle, WA 98119
206-297-1260
253-681-7667
sales@simulab.com
www.simulab.com

Established in 1994, Simulab Corporation is committed to providing medical simulators and procedure trainers to the medical education community. Through collaboration with leading educators and a specialized knowledge of materials and manufacturing processes, Simulab is a market leader in realistic, portable, and affordable solutions for a wide array of educational needs. Simulab's extensive product line includes TraumaMan®, the surgical simulator approved by the leading Surgical Education Society for its Surgical Skills Practicum and CentraLineMan™, a training platform for practicing Central Vascular Catheterization. For more information about Simulab, please visit www.simulab.com or call (206) 297-1260.

Tampa General Hospital– Booth 102

Pam Curtis, Senior Nurse Recruiter
1 Tampa General Circle
Tampa, FL 33606
813-844-4343
pcurtis@tgh.org
www.thg.org

Tampa General Hospital, located in the harbor of beautiful Tampa Bay, remains at the forefront of technology and innovation because of our never-ending quest to teach and learn. We are proud to announce that we just received the American Nurses Credentialing Centers Magnet Award for our commitment to excellence in nursing care. Join the talented professionals at TGH, one of only 150 hospitals to earn this distinction. To become a part of our award-winning team, see us online now: www.tgh.org

EXHIBITOR COMPANY INFORMATION

US Army Health Care Recruiting – Booth 302

SFC Abel Plasencio, Recruiter
3101 Maguire Blvd, Ste 166A
Orlando, FL 32803
407-896-0780
407-894-7528
abel.plasencio@usarec.army.mil
www.healthcare.goarmy.com

Offering full and part-time job opportunities with excellent benefits in addition to bonuses and loan repayment programs.

Vidacare Corporation– Booth 303

Bernadette Morales, Marketing & Events Manager
722 Isom Road
San Antonio, Texas 78216
210-587-4977
210-375-8537
www.vidacare.com

The EZ-IO® Vascular Access System by Vidacare Corporation provides immediate vascular access for the delivery of essential fluids using the intraosseous (inside the bone) space when traditional IVs are difficult or impossible. The EZ-IO is recognized as the technology standard for intraosseous access and has been inserted in over 350,000 patients worldwide. The system is deployed by 60 percent of US advanced life support ambulances and over half of US Emergency Departments, as well as the US Military. Established in 2001, Vidacare Corporation is the developer of a broad technology platform that is defining the new field of intraosseous medicine.

Wolfe Tory Medical, Inc – Booth 202

Brian Bechtel
79 West 4500 South Ste 18
Salt Lake City, UT 84107
801-281-3000
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ORAL & POSTER PRESENTATION ABSTRACTS - Evidence-Based Practice

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E15	**Laurie Flowers, RN, MSN, CCRN, CCNS**	*To Reverse or Not to Reverse: Warfarin Rreversal in the Traumatic Brain Injured Trauma (TBI) Patient*
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ORAL & POSTER PRESENTATION ABSTRACTS - Research

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R8	**John Recicar, MBA, MHA, RN**	*Patient Patterns of Injury From Motor Vehicle Rollover Ejection Crashes*
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R11	**Amber Kyle, RN, BSN**	*Seatbelt Compliance: Is Obesity a Factor?*
R12	**Daneen Mace Vadjunec, RN, BSN**	*The Silo Effect of a Trauma System in a Level I Trauma Center*
R13	**Heather Kulp, BSN, MPH**	*Unplanned Extubations in Trauma-related Intensive Care Units*

Evidence-Based Practice-E1

Oral Presentation - Advanced Practice SIG – Thursday, April 8, 2010 – 1:30-3:00PM

Abstract Title:

Advanced Practitioner Comprehensive Tertiary Survey including Incidental Findings: Improved Communication and Reduction of Missed Injuries

Authors:

Amanda McNicholas, MSN, CRNP; Tara Collins, MSN, CRNP; and Susan Butler, MSN, RN, CCRN

Background & Purpose:

As the number of trauma patients escalate, CT scan as a screening tool has also increased, making the prevalence of incidental findings and the risk for missed injuries rise. Our Trauma Advanced Practitioner (AP) team initiated a comprehensive tertiary survey form which holds the AP accountable for both a tertiary physical exam as well as communication of all incidental findings to the patient.

Study/Project Design:

This is a before/after observational study of a new documentation form.

Setting:

Busy Level II community Trauma Center without surgical residents, APs responsible for daily care.

Sample:

Convenience sample of all injured patients evaluated by Trauma Service, admitted from ED to critical care or a med/surg unit greater than 48 hours.

Procedures:

The APs were charged with creating a plan for completing the Tertiary Survey consistently. Incidental findings needed to be communicated with written discussions and follow up plans. To enhance documentation review boxes were added to the standardized daily progress note including verification of a radiologic and laboratory data review. Incidental Finding Forms were developed as two layer forms with an original copy for the medical record and a copy for the patient or family. The APs have the responsibility for communicating findings. Compliance of form use was tracked weekly by the APs checking all admissions from the last 24 hours on a random day of the week. Threshold of compliance was 95%. Goal was reduction in missed injuries and improved communication of incidental findings.

Findings/Results:

As the compliance to completing a Tertiary Survey increased, the number of overall missed injuries decreased. Over a three month period documentation compliance averaged 95% with missed injuries decreasing from 4% to 1%. This trend has continued over the next three month period signifying a true trend. Incidental Findings were successfully documented and communicated to patients, families, and their Primary Care Physicians for follow-up care. It has been of great value for the APs to play an active role in this process of instituting change to improve patient outcomes. The primary benefit of identifying missed injuries early in the hospital stay is the potential decrease in the overall length of stay in the institution with better rehabilitation outcomes. Equally important was the formal communication process documented for the Incidental Findings. Identification and improvement of follow-up of findings will enhance early treatment and improve patient outcomes.

Discussion/Conclusions/Implications:

The implementation of the tertiary survey form by the APs correlated with a decreased rate of missed injuries. Additionally, the progress note requires the AP to be accountable for completing an incidental finding form when necessary as well as tracking the patients primary care provider. The use of this form can be easily implemented by APs at other institutions. Further research is needed on the rate of patients who follow up on their incidental findings as well as the rate and type of incidental findings that were found to be clinically significant after further workup.

Evidence-Based Practice-E2

Oral Presentation - Military SIG – Thursday, April 8, 2010 – 1:30-3:00PM

Abstract Title:

Aeromedical Evacuation to Landstuhl Regional Medical Center: Opportunities for Improvement

Authors:

Kathleen Martin, RN; Liz Schell, RN; Raymond Fang, MD; Beth Cleek, RN; Connie Johnson, RN; Sean Kelley, RN; Sheryl Neal, RN ; and Pam Nyman, RN

Background & Purpose:

Aeromedical evacuation (AE) is a crucial, highly orchestrated component of modern combat casualty care. AE enables rapid patient movement across a global military trauma care system to progressively higher echelons of care. Prior to 2008, collaborative performance improvement (PI) processes did not exist between military trauma centers and the AE system supporting them.

Study/Project Design:

A descriptive study characterizing challenges in military aeromedical communication with LRMC.

Setting:

Aeromedical transport from Iraq and Afghanistan to Landstuhl Regional Medical Center.

Sample:

The charts of 724 patients evacuated via AE to LRMC were concurrently reviewed for PI events.

Procedures:

In 2008, Landstuhl Regional Medical Center (LRMC) and the U.S. Air Force AE system increased cooperative efforts to identify, to review, and to respond to AE-related PI issues. Emphasis was placed on the concurrent identification of potential PI events and the increased communication between ground-based and in-flight providers caring for evacuated casualties. Both standard and critical care AE teams participated directly in LRMC PI activities. Reviews and corrective recommendations were forwarded to the AE leadership. Involved providers received timely feedback.

Findings/Results:

In 2008, AE-related PI events captured in the LRMC Trauma Registry were reviewed relating to 34 patients (1.6 % of total patient transports). At times, more than one issue was identified per patient (Table 1). The PI event loop closure rate was 91%.

Table 1. Categories and incidence of AE-related PI Events

1. Improper AE care level (routine vs. critical care) – 6 (18%)
2. ICU team not activated for patient arrival – 15 (44%)
3. Equipment or supply issue – 3 (9%)
4. Significant clinical event
    - ICU team not activated for patient arrival – 15 (44%)
    - Equipment or supply issue – 3 (9%)
    - Decreased Respiratory Status – 13 (38%)
    - Decreased Systolic Blood Pressure – 8 (24%)
    - Vascular Event – 4 (12%)
    - Decrease in Hemoglobin – 2 (6%)
    - Decubiti developed – 3 (9%)
    - Medication Error – 2 (6%)

Discussion/Conclusions/Implications:

Open, formal communication and collaboration between the LRMC Trauma Program, U.S. Air Force AE teams, and U.S. Air Force AE leadership facilitated identification and investigation of PI events and implementation of corrective actions. Lessons learned were quickly incorporated into initial and advanced AE training programs and led to the creation of clinical practice guidelines. This AE PI process with its high rate of PI event loop closure improved care across the system for all patients.

Evidence-Based Practice-E3

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Buckle Up Tweens Program

Authors:

Sheri Stucke, PhD, APN; Jeanne Cosgrove, RN; and Melinda Case, RN

Background & Purpose:

Motor vehicle crashes are the leading cause of death in ages 8 to 15 years old. According to Clark County Child Death Review Team, Nevada, from 2005, tweens (ages 8 to 15) were the primary age group for motor vehicle related deaths. The baseline goal of implementing the Buckle Up Tween Program was to increase usage of seatbelts for ages 8 to 15 years old.

Study/Project Design:

Observational field study.

Setting:

School based elementary, middle and high schools.

Sample:

Convenience sample of children ages 8 to 15 years old. 973 children pre observational and 1021 childrne post.

Procedures:

Cars were stopped at a stop sign directly outside of the schools were preformed. A pre survey occured first in which data was collected on whether the child/children in the car was wearing their seatbelt and the location of where they were sitting in the car along with demographic data was collected. The intervention of a classroom presentation at the schools was then performed after the pre survey. Finally, a post survey was conducted approximately one week after the classroom presentation was given at each of the schools. The plan was to determine the effectiveness of the Buckle Up Tweens Program.

Findings/Results:

A total of 973 children were included in the Pre Survey Screening with 77% of males were buckled up, 81% of females were buckled up, 51% of males less than 13 years of age were in the back seat and 42% of females less than 13 years of age were in the backseat. Adults who were driving the vehicles were also evaluated which showed 90% of them were wearing seatbelts. Classroom presentations were held at 8 schools which included 8,666 children that participated in the program. Post survey results which occured 1 week after the classroom presentations showed 89% of females were wearing seatbelts, 80% of males less than 13 years old were in the back seat, 76% of females less than 13 years old were in the backseat, and 94% of parents/adults driving the vehicles were wearing their seatbelts.

Discussion/Conclusions/Implications:

The Buckle Up Tweens Program has been highly successful and very well received by the schools involved. In 2008, the program was implemented at 13 schools located in Clark County, Nevada. A large number of tweens sitting in the front seat in front of an air bag prematurely was identified. This program included an actual care stop at a stop sign, therefore, the child and adult were educated at the time of the stop. This method of education at the time of the stop was more successful than teaching adults and children outside the vehicle at another time.

Evidence-Based Practice-E4

Oral Presentation – Concurrent Session – Thursday, April 8, 2010 – 10:30-11:30AM

Abstract Title:

Development of a Geriatric Trauma Resuscitation Protocol, Utilization Compliance, and Outcomes

Authors:

Pamela Bourg, RN, MS; Melissa Richey, RN, BSN; Kristin Salottolo, MPH; and Charles W. Mains, MD

Background & Purpose:

The active 65+ age group is a growing demographic in the trauma population, yet there are few published trauma resuscitation protocols for this group. The purpose of this study was to develop a geriatric resuscitation protocol and measure compliance and outcomes in our geriatric trauma patients.

Study/Project Design:

Retrospective review of trauma geriatric patient clinical data from 1/2008 through 6/2009.

Setting:

Urban ACS verified Level 1 community trauma center in which 23% of trauma patients are 65 and over.

Sample:

All geriatric trauma patients (age 65+); patients who were DOA, discharged from the ED, transferred-out, or had no lactate record were excluded.

Procedures:

A geriatric resuscitation protocol was developed in 2008 after an increasing number of preventable and potentially preventable (P/PP) deaths were identified via PIPS. First, trauma activation guidelines were revised for all trauma patients. Second, a geriatric resuscitation protocol was developed that specifies 1) Lactate draw at admission; 2) Trauma surgeon consult if lactate is elevated (>2.5 mmol/l); 3) Central line and CVP monitor for patients with shock or elevated lactate who are not responsive to fluid resuscitation. Compliance was determined for each of the above three specifications in 2009, after the protocol was implemented. We used chi-square tests and Wilcoxon rank-sum tests to examine pre- and post-implementation mortality, hospital length of stay (LOS), and P/PP deaths.

Findings/Results:

There were 869 patients included in the analysis. The percentage of lactates drawn significantly increased across the six admission quarters (14%, 20%, 30%, 52% 55%, 73%, $p<0.001$). Compliance with the geriatric guideline in 2009 was as follows: 1) Obtaining a lactate, 64.5% (189/293); 2) Trauma surgeon consult following elevated lactate, 95.7% (45/47); 3) Central line and CVP monitor following shock or elevated lactate, 15.6% (10/64). Elevated lactate was observed in 26% of all patients. Mortality was significantly higher in patients with an elevated lactate (19.6%) v. normal lactate (4.9%, $p < 0.001$). Although not significant, unadjusted mortality was reduced approximately 40% in 2009 when examined by lactate levels (mortality in 2009 vs. 2008: normal lactate, 3.5% v. 6.4%; elevated lactate: 14.9% v. 24.4%). Mortality in patients with shock was 13.8% (n=4) in 2008 and 0% in 2009. LOS was similar in 2008 vs. 2009. Lastly, five P/PP deaths were identified in 2008 v. zero in 2009.

Discussion/Conclusions/Implications:

Our user friendly protocol is a clear roadmap for all specialties involved in the care of the geriatric trauma patient. The protocol can easily be disseminated to referring lower level trauma and non-trauma centers. Compliance with lactate draws significantly increased through development and implementation of the protocol. Compliance with the central line placement guideline might need improvement, while trauma surgeon consultation was high. Utilization of the geriatric protocol may have contributed to the reduced mortality in 2009. We will examine the remaining 2009 data in early 2010.

Evidence-Based Practice-E5

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Development of an Algorithmic Approach to Trauma Patients' Pain in the PACU

Authors:

Trisha Klein, RN and Kathryn Von Rueden, MS, RN, FCCM

Background & Purpose:

Pain in the trauma PACU is difficult to evaluate and manage since the patients may have challenging injuries, complex histories, and psycho-social issues. On a pain scale of 0 to 10, the average pain score was 6 in a sample of trauma PACU patients. A literature review revealed that a systematic approach to assessment and management can be effective.

Study/Project Design:

This initiative uses a pre and post intervention patient satisfaction survey comparison.

Setting:

Trauma PACU of a large, urban academic medical center.

Sample:

Post-anesthesia care unit specializing in trauma patients.

Procedures:

A team of trauma nurses met to discuss issues related to pain management practices. After brainstorming, problems with pain assessment were identified. From these sessions the need for standardized but flexible pain management approach evolved. The team then developed a systematic approach to assess and individualize treatment of the patients' pain. Five pathways or algorithms evolved. The first to be developed was the Pain Management Pathway. It addresses overall assessment of the pain and is used for all patients to categorize the type of pain the patient is having. Pain is classified into 4 categories and pathways, Aggressive, Acute, Supportive and PRN Pain Management Pathways. These allow individualization of the patients' pain management.

Findings/Results:

Currently, patient satisfaction data specifically related to pain is being collected for the pilot study. This data showed that a significant dis-satisfier with care was pain control. 2008 patient satisfaction data showed an average satisfaction score of 4.25 out of 5. To date, 2009 satisfaction data shows an average score of 4.40 to the question: "your pain was under control by the end of your stay in the trauma PACU," where 1 is strongly disagree and 5 is strongly agree. These data is an improvement of 0.15 on the satisfaction surveys compared with 2008 average. Patients have frequently stated having pain but identify that "the nurses really did all they could." Nurses report improved autonomy regarding their ability to adequately address their patients' pain. Also, patient care techs can take part in this model, increasing teamwork on the unit.

Discussion/Conclusions/Implications:

Implications for practice and research: Evaluation and appropriate management of pain in trauma patients is critical. Initial efforts to implement a standardized approach have had positive impact on staff and patients. This process has evolved into a research protocol to formally evaluate the impact of standardized pathways and nurse driven pain assessment and management.

Evidence-Based Practice-E6

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Development of Protocol to Detect At-Risk Drinking Behaviors in a Trauma Population

Authors:

Reda Willis, RN, MS, CCRN, MDiv; Amy Krichten, RN, BS, CEN; Keith Clancy, MD, FACS; and Kim Shoff, RN, BS, CCRN

Background & Purpose:

Excessive drinking is a risk factor for injury. Trauma centers need to have protocols in place identifying and intervening for at-risk drinkers, to prevent further injury. Previously this was addressed by obtaining a BAL on trauma patients and intervening if the BAL was positive. The goal of this project was to develop a protocol identifying patients for at-risk drinking regardless of their BAL.

Study/Project Design:

Beginning 2008 all trauma patients were screened for at-risk drinking with the Audit-C tool.

Setting:

Community teaching hospital (Level II designation) being upgraded to a Level I center Oct. 2009.

Sample:

This was a convenience sample (N = 1,201) of trauma patients admitted from February, 2008, to August, 2009.

Procedures:

A literature search was done on the best practices for screening and implementing a SBI program. At the same time, an expert speaker for SBI provided some educational groundwork to our staff on SBI. A protocol was developed in collaboration with our Social Work Department. A SBI documentation form and patient educational materials were developed. Education and a competency were developed for the staff. Accuracy and compliance with the protocol were monitored on a daily basis by the CNS. Feedback to the staff was given concurrently. The following outcome information was collected on each patient; age, BAL, Audit-C score, CAGE assessment, motivation to change score, willingness to comply with safe drinking limits, SA referral, or a recommendation to follow-up with SA upon discharge.

Findings/Results:

The total number of patients that were reviewed was 1,472. Of these patients, 1,201 had the screening completed. Two hundred seventy-one were not assessed due to cognitive issues, or the protocol was not completed prior to discharge. The number of patients with a BAL level over the legal limit was 334 (29%). However the total number of At-Risk patients numbered 463 (39%). The number of patients that scored At-Risk but had BAL of 0 or less than the legal limit, totaled 197 or 16.4% of the total population, or 42.5% of the total at-risk population. With our previous protocol of providing interventions and education only for patients with BAL over the legal limit, this group of patients would not have received education about "At-Risk Drinking" and Safe Drinking limits. This becomes an important group for injury prevention programs. By providing interventions and education on Safe Drinking, we may be able to change this group's behavior and prevent future injury.

Discussion/Conclusions/Implications:

Assessing all trauma patients for At-Risk Drinking, regardless of the BAL is extremely important. Our data suggests that many patients with BAL of 0 are At-Risk drinkers and may sustain a future injury. This aspect of injury prevention cannot be overlooked in our trauma centers.

We have now started to do follow-up phone calls with our patients who are At-Risk drinkers to assess their knowledge retention of safe drinking habits. This data will help us determine if we were successful with our educational program related to alcohol and trauma, as well as safe drinking limits.

Evidence-Based Practice-E7

Oral Presentation – Concurrent Session – Thursday, April 8, 2010 – 10:30-11:30AM

Abstract Title:

Erase the Pain: Initial Pain Management in the Trauma Resuscitation Bay

Authors:

Cynthia J Mastropieri, RN, MSN, CNS; Ginger Cunningham, RN; Dana R. Kennedy, RN, BSN; and Michael Foreman MD, FACS

Background & Purpose:

Pain was adopted as the 5th vital sign to improve management of pain. According to the literature, the time to administration of the first dose of analgesia in trauma patients in the Emergency Department (ED) exceeds 90 minutes. The purpose of this project was to determine if development of a pain protocol would decrease the time to initiation of analgesia and improved care in trauma patients.

Study/Project Design:

This is a before and after observational project design.

Setting:

An urban level I trauma and teaching center.

Sample:

The sample size included review of 35 charts of trauma activations before and after implementation of a pain protocol.

Procedures:

A multidisciplinary committee evaluated current pain management practices in patients admitted to the trauma resuscitation bay. The committee's goal was to develop and implement an analgesia protocol (Erase the Pain Protocol) to increase the percentage of trauma patients receiving analgesia during resuscitation and decrease the time from arrival to the first dose of analgesia. Inclusion criteria included trauma activations, hemodynamic stability, Glasgow coma score greater than 8, age greater than 12 years and a positive pain score. Trauma patients that met inclusion criteria were given weight base Fentanyl IV push within 30 minutes of bed placement with continuous monitoring of vital signs.

Findings/Results:

Review of 35 charts prior to initiation of Erase the Pain protocol revealed that 25% received analgesia administration within 30 minutes of arrival, 29% received analgesia administration greater than 30 minutes after arrival and 46% did not receive analgesia. After initiation of Erase the Pain protocol, 66% met the goal of analgesia administration within 30 minutes of arrival, 17% received analgesia administration greater that 30 minutes of arrival and 17% received no analgesia. There was a (41%) improvement in earlier administration of analgesia after initiation of Erase the Pain protocol which resulted in an average administration time of 16 minutes with a range of (6-30 minutes). In addition, trauma patients not receiving analgesia decreased by 31%. Challenges to the implementation of this protocol were affected by a newly redesigned ED, inexperience of ED nurses, open vacancies, extensive amount of ED nurses and surgical residents to educate and high ED volume.

Discussion/Conclusions/Implications:

Despite 25 years of research, pain management continues to be a challenge in trauma patients in the ED. Reasons for inadequate pain management include failure to assess initial pain, acknowledge the patients' pain, re-assess treatment adequacy and failure to meet the patients' pain management expectations. The implementation of an analgesia protocol (Erase the Pain protocol) resulted in a marked reduction in time to initial analgesia and improvement in the number of trauma patients receiving analgesia in the trauma resuscitation bay without adverse effects.

Evidence-Based Practice-E8

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Evaluation and Implementation of a New Treatment Modality for Rib Fractures: The Trauma Clinical Nurse Specialist's Role

Authors:

Lillian Aguirre, MSN, RN, CNS, CCRN, CCNS and Ernest F. Block, MD, MBA, EMT-P, FACS, FCCM

Background & Purpose:

Patients (pts) with uncontrolled pain from rib fractures (fxs) can lead to pulmonary complications. Transfers to higher level of care is a quality indicator and a target for improvement at our trauma center. Effective pain control may reduce these complications and transfers. Clinical nurse specialists (CNS) evaluate products and integrate their use as part of their role.

Study/Project Design:

Process Evaluation after implementation of a new therapy (tunneled catheter pump infusion).

Setting:

Community Hospital; Level 1 Trauma Center in the southeastern United States.

Sample:

The product and process for its use was evaluated on 5 adult trauma pts with multiple rib fxs and respiratory compromise.

Procedures:

The Trauma Quality team wanted to evaluate the use of tunneled catheters and an elastomeric pump for the infusion of bupivacaine to the rib fx site as an adjunct to systemic pain management for pts with rib fxs. The trauma CNS led efforts to evaluate the introduction of this new product, coordinate its use, and the impact on transfers to higher level of care. A multidisciplinary approach was used to develop a plan and process sequence for the device's use, electronic orders and documentation, and education of the physician, nursing and pharmacy staff. The CNS evaluated and reviewed all pts who had tunneled catheters inserted and tracked their outcomes during its implementation. Pain control and respiratory function was also assessed.

Findings/Results:

The product was evaluated on 5 pts, 3 were on a step-down unit, 1 on a general unit and 1 in the ICU that was intubated and on ventilatory support. None required transfer to the ICU or a higher level of care. The pt on the ventilator was successfully extubated 6 hours later. Both critical care and non-critical care pts with painful rib fx benefited from this therapy mode. They experienced relief from rib fx pain allowing them to increase their spontaneous volume, increase volume measurements during incentive spirometer exercises and ambulate in the absence of lower extremity trauma. It proved to be effective in managing rib fx pain. The coordinated efforts of the CNS with the surgeons, nursing, pharmacy and information services led to processes for safe bedside insertion, storage and retrieval of the catheters, filling of the pump and integration of documentation into the electronic medical record.

Discussion/Conclusions/Implications:

The evaluation process provided a test ground to consider potential future use of the therapy in this population. The CNS was pivotal for coordination and evaluation of this new pain management strategy. The CNS was able to demonstrate safe and organized use of the product and a procedure that could be implemented system-wide as an adjunct therapy for pain management that can lead to improved clinical outcomes. In conclusion, the CNS is in an ideal position to lead a comprehensive product evaluation and integration of this therapy with a multidisciplinary team.

Evidence-Based Practice-E9

Oral Presentation – Concurrent Session – Thursday, April 8, 2010 – 10:30-11:30AM

Abstract Title:

Financial Implications of Trauma: Development of a Trauma Billing Committee

Authors:

Michael Jordan, MSN, MBA, HC

Background & Purpose:

Trauma billing capture is essential for maintaining a trauma program. A billing committee ensures the accuracy documentation for national regulations for trauma billing. The purpose of this abstract is to discuss a trauma charge performance program that specifically monitors charges against the Uniform Billing Codes for Trauma Care.

Study/Project Design:

We reviewed documentation and charges in a level 1 trauma program.

Setting:

Free standing, not-for-profit, 250 bed, ACS verified Level I Pediatric Trauma Center.

Sample:

Our team reviewed patient charges and documentation twice weekly (n= 133 patients per quarter).

Procedures:

We evaluated trauma program financial statements, emergency department charge slips, and trauma flow sheets and identified an opportunity for performance improvement. We created a trauma billing committee to examine documentation for accuracy and consistency. The committee includes the trauma program manager, emergency department manager, emergency department education manager and revenue manager. Our team identified inaccuracies and provided feedback to providers. The review ensures charge accuracy based on UB 68X requirements. We found that there are opportunities for improved charge entry and capture documentation.

Findings/Results:

The committee reviews all trauma entries into the hospital within 1 week. We found that 14% (19/133) of charts lacked appropriate support documentation. Surprisingly, we noted that 38% (51/133) of the charge sheets reviewed failed to capture all chargeable nursing interventions and procedures. Our team routinely presents these errors to staff for reeducation. Based on our work, we modified emergency department charge sheets in accordance with the trauma team response revenue code (UB68X). Our team also shifted charge entry to revenue management staff. Our trauma team management is prospectively monitoring these changes.

Discussion/Conclusions/Implications:

Prior to the trauma billing committee, we inconsistently reviewed documentation for charge accuracy. Full time trauma coverage at verified/designated trauma centers is extremely costly. Between 1990 and 2005, over 300 trauma centers closed due to poor reimbursement and cost of care. We postulate that a trauma billing committee is essential for ensuring accuracy and additional performance improvement opportunities. Future health care reform will require improved fiduciary responsibility by trauma programs in the US.

Evidence-Based Practice-E10

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Implementation of a Geriatric Rib Fracture Protocol Improves Outcome

Authors:

Theresa Snavely, RN BSN; Jamie Miller, MSN, CRNP; Pamela Nichols, RN, BSN; Patricia Palubinsky, RN, BSN, Bonnie Wilson, MSN, CRNP; and Kazuhide Matsushima, MD

Background & Purpose:

Identification of UIC is a critical indicator of Trauma Performance. UIC is a clinical change warranting transfer of a patient to a higher level of care. We hypothesized that implementation of a geriatric rib fracture protocol would improve patient outcome by various discrete measures including decreased rate of UIC.

Study/Project Design:

Pre/post intervention study of blunt injured trauma patients over 55 with 2 or more rib fractures.

Setting:

Rural Level 1 Trauma Center, 500 bed academic medical center.

Sample:

Pre/post intervention (implementation of geriatric rib fracture protocol) of 401 patients requiring 139 UIC for the time period of 2005 versus 2006-8.

Procedures:

Analysis of trauma patient UIC in 2005 revealed the majority (74%) to be related to respiratory decompensation in the setting of rib fractures (55%). Thus, an interdisciplinary team of physicians, nurses and respiratory therapists developed a comprehensive Geriatric rib fracture protocol, comprising interdisciplinary educational forums, standardized order sets and daily patient updates. Concurrent variance monitoring and compliance was documented into Trauma PI database and fallout cases reviewed at weekly PI conference with aggregated outcome results reported quarterly at Trauma Quality Committee. Statistical analysis was via students testing or chi-square, as appropriate.

Findings/Results:

72 patients were studied in the PRE period compared to 329 in the POST. There was no statistical difference between average injury severity score24.56 vs. 21.51 (p=.09) or age 71 in both PRE and POST periods. Protocol compliance increased from 44% in 2006, and 96% in 2007 and 2008. (p = 0.001) There was a decrease in overall respiratory related UIC for trauma patients from 74% PRE to 43% POST (p=0.01). UIC for those over age 55 with 2 or more rib fractures decreased from 50% to 26% pre to post (p=0.04). ICU length of stay was reduced from 5.9 to 3.4 days (p=0.004) and vent days from 4.9 days to 1.9 days (p=0.09). Respiratory failure dropped from 20% to 16% PRE to POST. (p=0.38).

Discussion/Conclusions/Implications:

These data suggest an opportunity to address a special population with an empiric approach to pain management, pulmonary toilet and alert criteria to avoid UIC. Standard order set development and implementation ensured protocol compliance. A geriatric rib fracture protocol was effective in reducing UIC and improving outcome in a target patient population.

Evidence-Based Practice-E11

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Implementation of a Pediatric Trauma Continuity Clinic Utilizing the Medical Home Concept

Authors:

Karen A. Rodriguez, RN, MN, CPNP-PC/AC; Michael Jordan, MSN,MBA, HC; and Jeffrey S. Upperman, MD, FAAP, FACS

Background & Purpose:

Trauma is the leading cause of pediatric death and disability in our country. There are known gaps in access to pediatric trauma care and rehabilitation services. We postulate that aftercare is fragmented or non-existent. We propose that post-discharge medical home style care, championed by a pediatric nurse practitioner, leads to improved short term outcomes, caretaker and provider satisfaction.

Study/Project Design:

A descriptive study exploring patient, caretaker, and primary care provider verbal satisfaction.

Setting:

American College of Surgeons verified level I pediatric trauma center, outpatient surgery clinic.

Sample:

350 pediatric trauma patients evaluated since clinic inception, August, 2007.

Procedures:

Prior to the Trauma Continuity Clinic, the child's caretaker coordinated and ensured follow-up with specialty services involved during the acute trauma phase. The majority of our trauma patients required prior authorization from their primary care providers for subspecialty care. This resulted in fragmented or delayed aftercare.

After obtaining institutional and trauma program committee support, we instituted our trauma continuity clinic utilizing the medical home concept. All patients admitted and subsequently discharged from the pediatric general surgery trauma service were given a follow up appointment in our trauma continuity clinic 2-4 weeks after their discharge. Trauma continuity clinics are offered twice monthly and staffed by our Trauma Director and Trauma Nurse Practitioner.

Findings/Results:

After more than two years of providing this on-going service we find that patients and caretakers are gaining better access to not only their trauma related care needs but also their primary care health needs. By serving as the hub or home for these children and their caretakers, we ensure that the child is assigned to a primary care provider in their community.

Patients and caretakers report: fewer issues and barriers with access to care; improved understanding of their child's trauma related needs; and satisfaction with ability to access primary care health resources in their respective communities. In addition, community primary care providers are now referring their post-trauma patients, who were treated at other trauma centers, to our clinic for management and care coordination.

Discussion/Conclusions/Implications:

The goal of our clinic is to ensure that patients have access to subspecialty care. Transition of care is managed by the trauma nurse practitioner and we follow the case as needed to support the PCPs in determining proper access to services.

Trauma Continuity Clinic is essential to the ultimate recovery of our pediatric patients and their caretakers. We continue to face challenges related to reimbursement and recognition of these services as essential to the care of the trauma patient. These challenges as well as others will be presented.

Evidence-Based Practice-E12

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Infection Control Practice among Intensive Care Unit Patient Families

Authors:

Arielle Greenlee, RN, BSN, CCRN

Background & Purpose:

Why not have patient families' become a more positive aspect of an ICU patients' recovery process. A two month long observation revealed that <1% of family members consistently completed hand hygiene either before, during, or after visiting the patient bedside. Hand hygiene has been proven to reduce spread of infectious disease, reduce length of patient stay, and decrease accrued patient cost.

Study/Project Design:

Two month hand hygiene observational study completed before and after intervention implementation.

Setting:

One large university hospital 16 bed ICU setting with a very vulnerable patient population.

Sample:

Convenience sample of 30 patient family members before and 30 patient family members after hand hygiene brochure implementation within defined setting

Procedures:

An evidence based hand hygiene brochure was created addressing when, how, what, when, and why to wash hands, after interview data of patient families revealed a general ignorance of hand hygiene importance and impact. Brochure was implemented during the month of June 2009. Brochures were provided and taught to patient families by the bedside nurse during the first 24 hours of patient admission. After one month of brochure rollout, repeat observation and interview data would be completed.

Findings/Results:

100% adherence and amplified understanding among patient families' as evidence by improved audit and interview data after June 2009 brochure rollout. Family members have recently been witnessed holding physicians and other clinical and non-clinical staff accountable, acting as the patient advocate, and voicing institutional hand hygiene expectations. Readability, accessibility, easy of use, and visual appeal of brochure has added to consistency and compliance.

Discussion/Conclusions/Implications:

Including and educating family members during a time of crisis has proven difficult. Reliability of the bedside nurse to consistently use hand hygiene brochure can waver during times of stress and high workload. Positive reinforcement has shown to increase self-efficacy, and has added to consistency and compliance, although further tactics need to be explored. Future infection rate data needs to be collected to determine long term effectiveness and efficiency of hand hygiene brochure.

Evidence-Based Practice-E13

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Nurse-driven Transformative Change in Trauma Culture: Lessons Learned from an Academic Level I Trauma Center

Authors:

Alberto Bonifacio, RN, BSN; Jennifer Haynes, RN, BSN; and Jeffery Strickler, RN, MA

Background & Purpose:

Trauma resuscitations require exceptional leadership, communication, and teamwork to ensure quality care. This presentation aims to share the experiences and insights from a nurse driven campaign to affect comprehensive transformative change in trauma culture through implementation strategies, leadership, educational tools, and outcome measurement in negotiating institutional change barriers.

Study/Project Design:

This is a third party pre-and post-implementation observational field study.

Setting:

90 bed emergency department of a 726 bed academic, accredited Level I Trauma and state burn center.

Sample:

Prospective cohort of (n=29 pre and n=28 post implementation) all adult and pediatric trauma alert resuscitations occurring weekdays 0700-1900.

Procedures:

A Team STEPPS approach to changing culture was used in guiding our nurse-led campaign to improve trauma care. An eight-step plan with strategies focused heavily on team development and collaboration among leaders from eight clinical and ancillary services to achieve consensus of a shared vision and action plan. The emergency department implemented a Primary Trauma Nurse (PTN) Program from which to train, develop, and optimize nursing practice. A third party baseline and post-implementation study was conducted to assess change in both teamwork and clinical skills using the Team Event Non-technical Tool Skills (TENTS) and clinical management checklist derived from existing trauma protocols. Qualitative data was gathered via personal interviews and survey of program participants.

Findings/Results:

Our study revealed improvement in both teamwork and clinical performance. The TENTS criteria revealed the largest gains in leadership, situational monitoring and awareness, mutual support, overall teamwork, and communication. Clinical improvements were achieved in sequential physical assessment, pre-trauma huddles, PPE compliance, administration of warm fluids, and use of urine meters. Though overall teamwork and leadership means were improved, the Mixed Model Test applied revealed no statistical significance in either category ($p>0.05$).
The data collected from the focus group of program participants was largely positive indicating performance in trauma has greatly improved. Though the pre-and post-assessments yielded non-significant statistical results, the raw gains, positive focus group feedback, establishment of the PTN Program, and resulting wealth of nurse-developed training methods suggest a resounding practical significance.

Discussion/Conclusions/Implications:

In this ambitious project, impassioned nurses transcended their traditional roles to challenge inherent institutional obstinacy. Precious lessons were learned in the application of Team STEPPS, trauma field research, and the creation of a trauma nurse program. Vital insights were also gathered in nurse-driven multidisciplinary collaboration, policy development, trauma education, and political awareness. Our most profound discovery, however, was the potential for nurses, through effective leadership, innovation, and tenacity, to shift not only departmental, but institutional trauma culture.

Evidence-Based Practice-E14

Oral Presentation – Injury Prevention SIG – Thursday, April 8, 2010 – 1:30-3:00PM

Abstract Title:

SBIRT in a Pediatric Trauma Center: How and Why?

Authors:

Roni L. Robinson, RN, MSN,CRNP and Kara Noto, MSW, LSW

Background & Purpose:

Nationwide, the trauma center is becoming the setting for substance abuse screening, and until recently, the adolescent trauma patient was not routinely screened. In an effort to decrease the incidence of trauma morbidity and mortality, as well as decrease health care costs, our facility recently implemented new SBIRT standards of care for adolescents.

Study/Project Design:

Implementation process for new SBIRT standard of care for the adolescent trauma patient.

Setting:

Level 1 Pediatric Trauma Center, acute care trauma population.

Sample:

All admitted trauma patients to the acute care ward that are 12 years of age and older.

Procedures:

An SBIRT Task force made up of 2 Trauma Advanced Practice Nurses and a Trauma Social Worker was created. A thorough review of the literature was performed including: published methods of performing SBIRT in the trauma setting, benefits and efficacy of brief interventions, review of screening tools available, and local and national age of onset for substance use. Subsequently the group defined the target population and developed a screening and charting protocol. Staff was identified to monitor and evaluate the program. Lastly, the Task Force developed an information sheet for both patients and parents. Legal and Health Information Systems were consulted to ensure all hospital, local and federal regulations were followed. The program was initiated on March 23, 2009 with data collection.

Findings/Results:

Chart review established SBIRT was performed on 115 of 219 adolescent trauma patients in a 7 month time span, screening 25% of our target population. Positive screens (defined as answering yes to at least 1 of 6 questions about at risk behaviors about substance abuse) were found in 25% of respondents, displaying some type of risky behavior. Results demonstrated 62% of those screened answered yes to 1 question, 17% to 2 questions, 6% to 3 questions, 10% to 4 questions, 0% to 5 questions and 3% to 6 questions. All positive screens received a brief intervention (BI), except 2 patients who were discharged early. One referral was made for outpatient counseling. The SBIRT Program is reviewed every 3 months with all staff involved in the process. Trauma nurses are pleased with this program and eager to join in this area of trauma prevention. The trauma social worker, who provides majority of the BIs is considering ways to improve administration of the BI during high patient volume.

Discussion/Conclusions/Implications:

In light of the new ACS-COT standards for Level 1 Trauma Centers to identify individuals for substance use-related problems, our new SBIRT program has been extremely successful and a vital part of trauma prevention. With 25% of screens positive, the results demonstrate that the trauma nurse can use the SBIRT program to identify adolescents who may be on a path towards substance abuse and provide a much needed intervention in hopes of redirecting them. It only holds true that if you decrease the number of substance abusers, trauma-related injury due to substance abuse will decrease as well.

Evidence-Based Practice-E15

Oral Presentation - Neurotrauma SIG – Thursday, April 8, 2010 – 1:30-3:00PM

Abstract Title:

To Reverse or Not to Reverse: Warfarin Reversal in the Traumatic Brain Injured Trauma (TBI) Patient

Authors:

Laurie L. Flowers, RN, MSN, CCRN, CCNS and Daneen Mace-Vadjunec, RN, BSN, ONC

Background & Purpose:

Adults receiving pre-injury warfarin are at risk for sustaining severe TBI as a result of medically-induced coagulopathy. Concurrent chart audits revealed that TBI patients receiving warfarin were inconsistently reversed or not reversed in a timely fashion. The purpose of this guideline is to correct the patients' coagulopathy, prevent further hemorrhage and promote hemostasis.

Study/Project Design:

Measurement after implementation of a new practice management guideline.

Setting:

Level 1 Trauma Center.

Sample:

The sample includes all trauma registry patients admitted with a TBI who were receiving pre-injury warfarin for 9 months in 2009.

Procedures:

A multi-disciplinary team developed a reversal guideline and monitoring indicators. Warfarin reversal includes administration of plasma and intravenous vitamin K prior to transport to CT scan. The Blood Bank provides 2 units of thawed plasma immediately. Trauma Services implemented the guideline with an educational blitz to include surgical residents, physicians and nursing staff of the Emergency Department (ED) and SICU. Trauma Services shared the guideline with other regional trauma centers. Each trauma registry patient has a concurrent chart audit completed including warfarin reversal indicators. If warfarin is not/inconsistently reversed, the patients' care is reviewed at weekly trauma performance improvement meetings, which includes the Multidisciplinary Peer Review Committee.

Findings/Results:

38 trauma registry patients were admitted with pre-injury warfarin use and TBI. 31 patients were in compliance with the warfarin reversal guideline. The remaining 7 patients were discussed in-depth at weekly trauma performance improvement meetings. Two did not have timely warfarin reversal due to treatment delays in ED. Two were admitted to medical services. Three patients were admitted by trauma services. Of those patients, in 1 , the trauma surgeon chose not to reverse the warfarin based on the patients' minor injury and clinical presentation. A communication breakdown between the trauma surgeon and the ED physician delayed treatment in another patient. Lastly, the third patient was not reversed based on a history of severe congestive heart failure. Of the 31 patients who were reversed per the practice management guideline, two patients developed an acute exacerbation of congestive heart failure during the administration of thawed plasma. There were zero transfusion reactions.

Discussion/Conclusions/Implications:

At discharge, 35 patients had GCS > 9 and 3 were GCS < 5. Coagulation factor VIIA role warfarin reversal is unclear and platelet inhibitors, aspirin and clopidogrel pose challenges in TBI patients. Trauma Services is developing a guideline for platelet inhibitor reversal and continues to share the guideline with medical physician(s). Ongoing education includes refreshing the various staff within the hospital and referring hospitals. As the patient advocate, nurses play a pivotal role in prompt identification of the medically-induced coagulopathic patient and informing physicians.

Evidence-Based Practice-E16

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Trauma Boot Camp: Multidisciplinary Simulation Training Designed to Improve Resuscitation Care and Communication

Authors:

Marla L. Vanore, RN, MHA; Marie Campbell, RN, MSEd, MS; Kristine Biggie, RN, MSN, CRNP; and Roberta Hales, MHA, RRT-NPS, RN

Background & Purpose:

Pediatric trauma resuscitation requires a high level of expertise and team performance to rapidly assess and treat the injured child. High fidelity simulation is a tool being used to enhance healthcare training and education. After 1 year of trauma simulations, an innovative Trauma Boot Camp was designed and implemented to orient new physicians and as a refresher for nurses and others.

Study/Project Design:

Education session including didactic, trauma simulation, skill stations and written evaluations.

Setting:

An academic Level I Pediatric Trauma Center.

Sample:

50 attendees: Emergency Medicine (EM), Trauma, Surgery and Critical Care(CC) Fellows, ED Nurses, Respiratory Therapists, Radiology Technologists.

Procedures:

Monthly trauma activation simulations using high fidelity patient simulators have been conducted for one year at this Pediatric Trauma Center. With the start of a new academic year, an intensive 5 hour interactive education program was designed and implemented. Course objectives included: Describe specific pediatric considerations to be considered in trauma activations and demonstrate successful communication techniques. The schedule of the day included: didactic lectures given by physicians and nurses which included communication techniques, clinical care and institutional specific processes; 2 trauma scenarios based on actual cases (an infant head injury from abuse and an adolescent GSW) and skill stations (chest tubes, intraosseous insertion and hare traction splints).

Findings/Results:

Attendance at the Trauma Boot Camp was excellent from most areas. This included all 10 EM Fellows, 18 ED nurses, 8 CC Fellows, 3 Respiratory Technicians, 8 Radiology Technologists. The neighboring adult trauma center sent 3 trauma fellows. The 3 Surgery Fellows did not attend due to patient care time conflicts.

A 5 point Likert Scale was used to evaluate the educational session. Overall evaluations were positive. A sample of the results is as follows:

- The objectives of the Boot Camp were clearly stated 4.55
- The format of the Boot Camp was effective 4.58
- The Boot Camp was challenging 3.69
- The Boot Camp was appropriate for my level of learning 4.25
- I would like this type of Boot Camp again 4.39
- I plan to utilize what I learned into my practice 4.67

The discipline that rated the experience lowest were Radiology Technologists since only one scenario allowed their participation and the skill stations did not address their needs.

Discussion/Conclusions/Implications:

Trauma Boot Camp utilizing high-fidelity simulation and skill training is perceived to be an effective method to educate a multidisciplinary group of pediatric fellows, nurses and allied health providers. Lessons were learned; 1) Time commitment for interactive group education is considerable and must be anticipated; 2) All disciplines need to have roles in scenarios. 3) Logistics such as size of the space, availability of equipment in multiple sites, equipment budget commitment and need for further development of pre-course handouts were noted. Annual Trauma Boot Camps are planned.

Evidence-Based Practice-E17

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Trauma Return Appointment Study

Authors:

Melissa Hlavaty, RN, BSN, CCRN and Christina Wargo, RN, MSN

Background & Purpose:

Patient complaints identified a lack of appointments. Johnson et al 1 reported strategies to improve patient compliance as education, reminders, sanctions, and open scheduling. Chung et al 2 reported obstacles as wait times and quality of exam. Murdock et al 3 repors forgetting as the number 1 reason for missing a return. C. Gainer 4 reports communication as the key to patient return.

Study/Project Design:

Prospective patients were reviewed and follow-up appointment scheduling evaluated as a PI initiative.

Setting:

Geisinger Medical Center serves > two million residents of central and northeast Pennsylvania.

Sample:

Geisinger Medical Center serves > two million residents of central and northeast Pennsylvania.

Procedures:

Trauma patient logs admitted to GMC are reviewed daily. 88% of patients returned for follow-up. Non compliant patients were called by a RN for follow-up.

Four categories were identified:

1. Appointment scheduled, patient complied
2. Appointment scheduled, patient not compliant
3. Appointment not scheduled, patient called to schedule
4. Appointment not scheduled, patient did not call, no patient follow-up

Priority was given to the 2nd, 3rd and 4th categories with a performance improvement (PI) plan.

1. Appointments were verified electronically, missed appointments were scheduled.
2. The process for scheduling appointments was clarified.
3. A 91% compliance achieved by October 2007.
4. All non-compliant patients were called by an RN as follow-up.

Findings/Results:

1. 10 % of patients do not return to our trauma clinic, but rather preferred follow-up with a provider closer to home.
2. Multiple appointments on one day are a positive for patients and families decreasing travel time and patient expense.
3. An integrated system improved compliance for scheduling appointments.
4. Updates in the hospital electronic chart occurred between October of 2007 and December 2007. Scheduling appointments became entirely electronic and upon review of data from January 2008 and February 2008 the follow-up appointment compliance rate increased to 99.2% with 0.8% of the patients following up at outside facilities closer to home or with primary care physician.

Discussion/Conclusions/Implications:

The most important learning opportunities are:

1. Integrated systems improve patient care.
2. Including discharge appointments as part of the discharge instructions help reinforce to patients the priority of the return appointment. The halo effect of scheduling return appointment on discharge is increased staff awareness.
3. Matching multiple department appointments on the same day increased compliance for all appointment

Evidence-Based Practice-E18

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Under the Influence: Are We in Denial?

Authors:

Jan Simonson, MSN, RN

Background & Purpose:

Alcohol and other drugs use/abuse is a significant, preventable health issue that contributes to the escalating incidence of traumatic injury, costing society nearly $200 billion annually. For northern and central WI trauma patients, alcohol and other drug use is a contributing factor in nearly 25% or ¼ of the population. It was essential to develop a process to address these issues in a timely manner.

Study/Project Design:

AODA report demonstrating CAGE assessment completion, frequency of AODA consults/brief intervention.

Setting:

Saint Joseph's Regional ACS Verified Level II Adult and Pediatric Trauma Center.

Sample:

All trauma registry candidates > 10 yrs. of age were screened for alcohol/other drug usage with subsequent AODA consultation for any positive results.

Procedures:

The collaboration of the Trauma Team, AODA Leadership Team and Health Information System Team brought the following items to discussion: CAGE assessment completion, Tox Screen results, standard consult to the Certified Addictions RN, and brief intervention completion. RN and trauma staff education was facilitated through a self-guided Power Point. Pre-printed admission orders were updated to include an AODA consult. Guidelines for Trauma Patient referral to AODA screening was implemented utilizing literature evidence. An automated report was built to monitor the above components and is generated monthly to identify gaps in the management of patients with alcohol//other drug issues. This report is analyzed monthly by the Trauma PI RN and Certified Addictions RN for process gaps.

Findings/Results:

Staff RN education improved completion of the CAGE assessment. Inclusion of the AODA consult on the pre-printed admission orders facilitated appropriate consults in a timely manner. Monthly reports indicate improvement in CAGE assessment from the 70th percentile to the 90th percentile. AODA consults have increased to nearly 60% with brief intervention completion near threshold of 65%. Gaps in consultation continue to be addressed on a case by case basis. Short weekend stays when AODA staff is not readily available is addressed in a variety of methods.

Discussion/Conclusions/Implications:

Development/implementation of AODA management guidelines was pivotal to improved holistic care of the trauma population. Open communication among trauma team members has decreased gaps from admission to AODA consult. The benefit of standardized serum and urine toxicology screening of all trauma patients needs to be further explored. As there is no follow-up method established, effectiveness of the brief interventions are unclear. Development of follow-up protocols needs to be explored to fully understand the effectiveness of screening and brief intervention.

Research-R1

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Brief Intervention: Risk Factors for Failure in a Level One Trauma Center

Authors:

David C. Maynard, MA, LPCC, NCC; Andrew Bernard, MD, FACS; and Lisa J. Fryman, RN

Background & Purpose:

Drug (DR) and alcohol (ALC) abuse is common among trauma victims. Brief interventions (BI) are performed to garner internal motivation for behavioral change (BC), which is associated with lower trauma recidivism. BI results in BC in more than half of trauma victims using ALC but the level of commitment to BC after BI in patients using DR other than ALC has not been established.

Study/Project Design:

This is a retrospective study.

Setting:

University of Kentucky Chandler Medical Center, Level One Trauma Center.

Sample:

Trauma patients admitted from August 2008 - July 2009.

Procedures:

The trauma database at our ACS-verified level I trauma center was queried from August 2008 - July 2009 (12 months) to identify patients with positive serum ALC or urine DR. BI data obtained by our Licensed Professional Clinical Counselor (PC) were analyzed to determine rate of commitment to behavioral change. Comparison of groups was performed with Student T-test.

Findings/Results:

The University of Kentucky Trauma Center admitted 2980 in the aforementioned timeframe and 1192 were found to have abnormal serum ALC or urine DR assay. BI was administered to 342 patients, with 46 being eliminated due to the patient's medical condition or medical information being unavailable. One patient was admitted twice, with one visit being eliminated. Intervention was delivered to 102 patients for ALC-use alone and 194 for other DR (+/- alcohol). The mean age of those admitted was 42.5 ¬± 22.09, with females accounting for 32.19%. The mean age of those receiving BI was 35.02 ¬± 11.98, for ALC alone was 37.61 ¬± 13.4 and 33.38 ¬± 10.9 for other DR, $p< 0.01$. Each patient was categorized by the PC into the various Stages of Change. Of those using ALC, 71.6% were rated at Contemplation and above and 55.7% for those using DR (chi-square test of difference $p < 0.01$).

Discussion/Conclusions/Implications:

BI is not more challenging in DR patients than in ALC. Younger patients, however, may need alternative forms of BI. Because the rate of change is insignificant, it would appear recidivism after discharge would be the same. However, these data reinforce the need for a fully integrated BI program in trauma centers and greater scrutiny of some substance using trauma victims.

Research-R2

Oral Presentation - Military SIG – Thursday, April 8, 2010 – 1:30-3:00PM

Abstract Title:

Caring for Wounded Warriors: Development of Performance Improvement (PI) Knowledge for Deployed Trauma Nurse Coordinators (TNCs)

Authors:

Rose Bolenbaucher, MSN, RN; Captain Lisa Compton, BSN, RN; Nancy Molter, RN, PhD; Joanna Moore, MPH; Mary Ann Spott, MPA, MBA; and Tracy Cotner-Pouncy, RN

Background & Purpose:

In 2003 the Joint Theater Trauma System (JTTS) with an integrated Joint Theater Trauma Registry (JTTR) for military operations was initiated. The primary goal of the system is PI with TNCs working with staff to integrate PI initiatives. The purpose of this review was to determine if the evolution of education of TNCs in PI concepts reduced the number of audit filters identified.

Study/Project Design:

A descriptive study to explore the evolution of the JTTS TNC PI curriculum.

Setting:

Combat casualty care environment within the context of a military theater trauma system.

Sample:

Randomized sample of 583 individual records with Military ISS scores between 16-50 reviewed for PI audit filters.

Procedures:

During the time period of Oct 2007-Sepember 2009 there were four teams of TNCs deployed to theater in 6- month rotations. Within the 4 teams, 3529 wounded warriors were identified in the JTTR with valid ISS scores. Of these, 583 had Military(MIL) ISS scores between 16-50 (10%-20% per team). The 583 records were then randomized within teams to 50 records per team. Each of the 50 records per team were reviewed for audit filters identified only in theater. Each record represented care to an individual patient.

Findings/Results:

The 583 records with MIL ISS scores of 16-50 were categorized by the time frame each team was in theater: Team 1(Oct 07-Mar 08)-158 records; Team 2 (Apr 09-Sep08)-176 records; Team 3 (Oct 08-Mar09)-94 records; and Team 4 (Apr-09-Sep-09)-155 records. Fifty (50) records were randomly chosen for each team for review. Records reviewed represent, for each team respectively, 32%, 28%, 53% and 32% of the team records with MIL ISS scores of 16-50. Team 1 identified 26 filters in 16 records (32%); Team 2 identified 17 filters in 13 records (26%); Team 3 identified 9 filters in 9 records (18%) and team 4 identified 10 filters in 7 records (14%).
TNC PI education evolved from 1-2 hrs to a more integrated approach over two weeks involving approximately 40 hrs of PI content. Although there is a trend of finding less audit filters from the first team to the fourth, there are no statistical differences between teams.

Discussion/Conclusions/Implications:

There is evidence that the frequency of patient records with audit filters has decreased as the education program for TNCs has evolved in the PI content. The lack of statistical significance may be due to the low volume of records reviewed and the short time span of curriculum changes. Currently, a concurrent feedback mechanism of the PI data entered in the JTTR is being developed to evaluate accuracy and the relationship of the audit filters to the complications as a reflection of the quality of PI activities. This training curriculum may be a model for consideration in the civilian sector.

Research-R3

Oral Presentation – Concurrent Session – Thursday, April 8, 2010 – 9:15-10:15AM

Abstract Title:

Compare Pediatric Bowel Injuries from Trauma Requiring Surgical Intervention to Help Predict Outcome

Authors:

Maria F. McMahon, MSN, RN, CPNP-AC and David P. Mooney, MD, MPH

Background & Purpose:

There are few research studies comparing pediatric small bowel and colon injuries. The purpose of this data review was to compare patients who sustained a small bowel injury, colon injury or combined injury and required surgical intervention. We looked at the number of complications and outcomes. This information could help anticipate complications and outcomes based on bowel injury diagnosis.

Study/Project Design:

Multi-center, retrospective cohort study.

Setting:

Level 1 Pediatric Trauma centers, multi-center project.

Sample:

Multi-center convenience sample of 328 pediatric patients </= 15 years of age.

Procedures:

Data consolidated by a group of pediatric trauma centers on all patients admitted with a bowel injury requiring surgical intervention was evaluated. The patients were sorted into categories of small bowel injury, colon injury and combined (both small bowel and colon). Excluded were patients with a stomach, duodenal or rectal injury.Demographics included were age, gender, ISS, mechanism of injury and other injuries sustained. Whether a laparoscopy and/or laparotomy was done, the surgical repair performed, length of hospital stay (LOS) in days, early and late complications were all reviewed. The total number of patients and percentage for categories were tallied and evaluated. The demographics, complications and outcomes were summarized. A literature search and review was also completed.

Findings/Results:

Of 328 participants, 246 met the criteria to be included in this study. There were 126 small bowel, 42 colon, and 78 combined injuries. The highest percentage from mechanism included 58% from a motor vehicle crash, 12.6% bicycle, and 7% ATV accidents. More males sustained small bowel and combined injuries where more females sustained colon injuries. The average age and GCS for all three categories were statistically the same 8 - 9 years of age and GCS of 13 - 14. Average LOS was 9 days, 14 days and 13.7 days respectively for small bowel, colon and combined injuries. The average ISS for small bowel 13, colon 15 and the highest for a combined injury was 18. Small bowel and combined injuries had a higher percentage of both early (22% and 28%) and late (8% and 16%) complications than colon injury (12% and 2.4%) alone. There were 6 deaths from the abdominal injuries, 4 had small bowel injuries, 1 colon and 1 combined.

Discussion/Conclusions/Implications:

We found that patients with combined small bowel and colon injuries have a higher ISS score, a longer LOS and a higher percentage of early and late complications. It was also shown that small bowel injuries had a higher percentage of complications compared to colon injury yet the LOS was shorter. These results suggest that more research needs to be done to identify the reasons for and prevent complications especially for the small bowel and combined injury groups. Length of stay is one aspect of care for the small bowel injured group that should be evaluated more closely.

Research-R4

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

High Risk Alcohol Use: Initial AUDIT Score During Hospitalization Compared to AUDIT Score at 3-6 Month Follow Up Call

Authors:

Starre Haney, RN, MS; Fred Beyer, BA, CL; and Kimya Felton Tambuzi, BS, CL

Background & Purpose:

High risk alcohol use is a factor in many trauma patients‚Äô injury event. The purpose of this study was to examine the effectiveness of brief interventions conducted with hospitalilized patients that screen positive for high risk alcohol use. Their inpatient Alcohol Use Disorders Identification Test (AUDIT) score was compared to their score after discharge.

Study/Project Design:

This is a single center pre and post observational study.

Setting:

An Academic, Urban, Safety Net, Level I Trauma Center .

Sample:

This was a convenience sample of 40 patients that received alcohol screening and brief intervention who were available by telephone after discharge.

Procedures:

The Trauma Services Alcohol and Drug Intervention program utilized Interventionalists who conducted screenings and brief interventions with hospitalized patients. High Risk Alcohol Screening was completed using the Alcohol Use Disorders Identification Test (AUDIT). A numerical score (from 0 to 40 points) was calculated based on patient self-reported alcohol use habits. Patients received appropriate referrals after intervention. A post discharge telephone call was made 90 to 180 days after discharge and another screening was completed. At least 3 attempts were made to contact discharged patients. The primary outcome was the change in scores from hospitalization to discharge. In addition to the AUDIT scores, age, gender, ethnicity, BAL, ISS and MOI was recorded for analysis.

Findings/Results:

Of the 40 patient that were reached by telephone, 27 were trauma patients and 13 were medical admissions. A paired samples t test revealed post AUDIT scores were significantly lower than pre-AUDIT measurements ($p<0.001$). The mean initial AUDIT score was 23.98 and the mean of the 2nd AUDIT score was 10.13. One way ANOVAs determined there was no change in AUDIT scores by ethnicity or gender. There was a significant effect for age group ($p<.05$). Follow up comparisons revealed that the decrease in AUDIT scores was significantly greater for the 46+ age group versus the 31-45 age group and the 30 and under age group. There was also a correlation between the BAL and the 46+ group with BAL increasing with age. In examining the mechanism of injury (MOI) vs. the medical admission group 3 groups were utilized (MVC, Medical & Other) due to the low samples in various MOI categories. The Medical group decrease in AUDIT scores was greater than the Other group. BAL and ISS did not vary by ethnicity.

Discussion/Conclusions/Implications:

The significant decrease in AUDIT scores is encouraging. The program may be effective for both trauma and medical patients. The age group 46+ had higher alcohol levels and also had the most significant change in AUDIT scores. The Alcohol and Drug Intervention program is new and evaluation of its effectiveness is ongoing. As part of the resource referral process, patients are now being informed of the follow up phone call. This may increase the number of telephone contacts/second AUDITS that are performed. A future study looking at interventions by age group may improve patient outcomes.

Research-R5

Oral Presentation – Concurrent Session – Thursday, April 8, 2010 – 9:15-10:15AM

Abstract Title:

Is It Us or Them? Who Fails at Follow-up

Authors:

Nancy Martin, RN, MS, ACNP; Ajai K. Malhotra, MD; Melanie Jacoby, RN, BSN; Janie Tarrant, RN, BSN; Kelly Guilford, RN; and Rao Ivatury, MD

Background & Purpose:

Poor follow-up by trauma patients results in a lack of knowledge of post discharge health related issues. In the current study we hypothesize that there are significant institutional barriers at the trauma center (TC) preventing patient follow-up.

Study/Project Design:

Telephonic survey of trauma patients post hospital discharge over a one year period.

Setting:

State designated and American College of Surgeons verified Level I academic urban Trauma Center.

Sample:

All trauma patients discharged to home from the trauma service over the one year study period (n=940).

Procedures:

All patients meeting entry criteria had telephonic follow-up attempted three times within four weeks of discharge to: 1. evaluate the general well being of the patient; 2. enquire about follow-up; and 3. question if the patient had experienced any difficulty following up at the TC.

Findings/Results:

Among the 940 patients meeting entry criteria, contact was established with 755. From the details of injury, follow-up was deemed important in 744. Among these, 123 (16%) chose to follow-up outside of the TC, 588 (79%) followed up at the TC, and 33 (5%) chose not to follow-up at all. 147/744 (20%) of the patients reported some barrier to follow-up at the TC. The barriers to follow up were: language-36, poor discharge instructions-52, call center difficulty-52, affordability-4, and other-3. Twenty of these patients had significant medical issues requiring follow-up (casts-2; sutures-6; hard collar-12).

Discussion/Conclusions/Implications:

Institutional barriers at the TC play a significant role in poor follow-up by trauma patients. These barriers need to be identified and addressed in order to provide optimal care post-discharge.

Research-R6

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Monitoring Motor Vehicle Passenger Restraint Usage at an Amusement Park

Authors:

Michelle Marcum, RN, BS; Gordon Lee Gillespie, RN, PhD, PHCNS-BC, CEN, CCRN, CPEN, FAEN; and Margot Daugherty, RN, MSN, MEd, CEN, EMT-P

Background & Purpose:

Motor vehicle restraint use is one strategy to prevent death and disability following a motor vehicle crash. As a result, Ohio will require children 5-7 years to be restrained in a booster seat in motor vehicles. The compliance to the pending law change was not known. The study purpose was to determine if age appropriate restraint use occurred in motor vehicle occupants prior to law initiation.

Study/Project Design:

An observational, non-experimental design was used in a community-based setting.

Setting:

Data were collected at the parking lot exit of an amusement park in a large Midwestern U.S. city.

Sample:

A convenience sample was used with park patrons exiting the parking lot. Data included 549 drivers and 410 passengers occupying 261 motor vehicles.

Procedures:

Trained observers used the Motor Vehicle Passenger Restraint Tool to document age-appropriate restraint use for passengers in motor vehicles over an eight week period during summer 2009. Business vehicles were excluded. Drivers were then encouraged to buckle themselves or appropriately restrain passengers as warranted. Stickers were provided to child passengers. Data were double-data entered into a spreadsheet and a cross-case analysis to identify and correct data entry errors. Descriptive statistics (counts, frequencies) were used to analyze the data. Exempt IRB approval was granted prior to study initiation.

Findings/Results:

Data were collected from 549 motor vehicles. Mean age for children was 8.6 years (standard deviation 4.778). Mean age of adult drivers was 38.8 years (standard deviation 12.7). Driver's seatbelt compliance was 85.8% (n=471). Passenger data were collected from 261 motor vehicles. Passenger's age appropriate restraint compliance was 75.6% (n=310). Passenger'sge appropriate restraint use included infants in rear facing infant car seats (n=3 of 3, 100%), children ages 1 to 4 in weight appropriate convertible car seats with a five-point harness (n=65 of 71, 91.5%), children ages 5-7 in booster seats (n=49 of 75, 65.3%), and persons 8 through adulthood (n=193 of 241, 80.1%).

Discussion/Conclusions/Implications:

State motor vehicle restraint legislation does not automatically translate to age appropriate restraint use in motor vehicle passengers. It may be necessary to target public health education for populations such as children ages 5-7 in school settings, allowing their participation in their own safety outcomes. It may also be necessary to make motor vehicle restraint use a primary traffic offense. This legislative change could further increase restraint use compliance. Research is needed to test school-based interventions aimed at increasing booster seat compliance for children ages 5-7.

Research-R7

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Parental Recognition of Post-Concussive Symptoms in Children

Authors:

Penelope Stevens, MSN, RN, APRN; Barbara Penprase, PhD, RN; James Dunneback; and John Kepros, MD

Background & Purpose:

Many children who have a mild TBI will have persistent post-concussive symptoms. Parents may not always attribute these symptoms to their child's head injury. Recognition and treatment is essential to help the child reach optimum cognitive potential. The purpose of this study is to identify if parents of children who have a mild TBI are able to recognize post-concussive symptoms in their child.

Study/Project Design:

This is a descriptive study, which surveyed parents of children discharged from the ED with mild TBI.

Setting:

Pediatric Emergency Department in a Level 1 Trauma Center.

Sample:

A convenience sample of 120 consecutive ED patients between 5 and 17 years of age with mild TBI was identified, and their parents surveyed.

Procedures:

Parents with a child who was seen and discharged from the ED with mild TBI were given standard written and oral discharge instructions. These parents were surveyed by telephone two to five days after injury to determine if they were aware of any post-concussive signs or symptoms in their child based on their discharge instructions. They were then read a list of signs and symptoms commonly seen in post-concussive children, and asked if their child had exhibited any of these. Results for each parameter were analyzed in aggregate to determine parental recall, reported frequency of each sign or symptom, and to identify any relationships between gender, age, type of injury and symptomatology if data permits.

Findings/Results:

Consent was obtained from parents of 105 children who met inclusion criteria. Mean age of the children was 10.4 years (range 5-17 years), with 2:1 male predominance. Mechanisms of injuries included being struck (48.6%), falls (40%), ATV/dirt bike/motorcycle (6.7%), and MVC (4.8%). Of those who were struck, 80.3% were sports-related, with football and soccer injuries most commonly reported. A total of 66 (62.9%) children had post-concussive signs and symptoms. Of these, 32 (48.5%) had parents who had identified and were aware of their symptoms. Parents of the remaining 34 (51.5%) children denied any symptomatology, but when read a list of post-concussive signs/symptoms, identified one or more symptoms in their child. In both groups the most commonly reported symptom was headache, followed by nausea, and feeling slow or sluggish.

Discussion/Conclusions/Implications:

Although the majority of children seen and discharged from the emergency department with mild TBI exhibited post-concussive symptoms, only about half of their parents were able to identify and relate those symptoms to the head injury, despite verbal and written discharge instructions. Further research is needed to determine the most effective method and timing of education, in order to properly identify and treat those children at highest risk. Follow-up telephone calls may prove useful in identifying symptomatic children, and arranging for appropriate referral when indicated.

Research-R8

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Patient Patterns of Injury from Motor Vehicle Rollover Ejection Crashes

Authors:

John Recicar, MBA, MHA, RN and Kimball Maull, MD

Background & Purpose:

The under utilization of safety belts increases the likelihood of morbidity, mortality and can result in temporary or permanent disability when patients are involved in motor vehicle crashes. This study was to determine if there is a specific pattern of injury associated with motor vehicle rollover ejection crashes in Qatar, a quickly developing oil and gas rich nation in the Middle East.

Study/Project Design:

This is a retrospective review of trauma registry data.

Setting:

Hamad General Hospital, the State of Qatar's only trauma center and tertiary care center.

Sample:

All patients who were involved in motor vehicle rollover ejection crashes for a two year period from 1 November 2007 to 31 October 2009.

Procedures:

The patient data abstracted included demographics, crash characteristics, injury pattern data, operative procedures during the hospital course and length of stay.

Findings/Results:

One hundred twenty seven patients were admitted after rollover ejection crashes. 93% were male and 7% were female with a median age of 26 years. The location within the vehicle was unable to be determined in seven patients. Multi-system injuries occurred in 77% of patients and involved head injuries 65%, neck injuries 3%, spinal injuries 39%, facial fractures 20%, chest injuries 66%, abdominal injuries 33%, extremity injuries 60%, and external injuries 22%. Operative procedures were required in 38% with orthopedic 17%, abdominal 8% and neurosurgical 8% being the most common.

Single system injuries involved the head 67%, spine 10%, abdomen 10%, extremities 3% and external 10%. Operative procedures were required in 7% with orthopedic 50% and abdominal 50% procedures being the most common. Mean hospital length of stay (LOS) was 20 days for multi-system vs. 4.7 days for single system. The mean ISS was 23 vs. 18 and the in-hospital adjusted mortality was 25% vs. 21%.

Discussion/Conclusions/Implications:

Motor vehicle rollover ejection crashes cause injuries with high injury severity and result in multi-system injuries in most patients. Compared to those with single system injury, patients injured in crashes with multi-system involvement had increased hospital LOS and utilization of resources. Head injuries predominate and appear to determine mortality, which was similar in both groups. Enhanced enforcement of current seatbelt laws, and the utilization of safety belts by all vehicle occupants may reduce the impact of such violent crashes.

Research-R9

Oral Presentation – Injury Prevention SIG – Thursday, April 8, 2010 – 1:30-3:00PM

Abstract Title:

Patient Teaching Materials on the Risk of Falling While Anticoagulated: Is Consumer Input Useful?

Authors:

Sheree Brown, BSN, RN; Madonna R. Walters, MS, RN; Mary-Anne Purtill, MD, FACS; and Richard Pomerantz, MD, FACS

Background & Purpose:

Anticoagulated trauma patients present major challenges. While many trauma centers have protocols to rapidly reverse anticoagulation, there is greater promise for improved outcomes if these patients seek prompt medical care after a fall or injury. The study‚Äôs purpose was to evaluate the design and readability of an original educational brochure, produced to improve patient awareness.

Study/Project Design:

This was an 8-item consumer survey, using a 4-point Likert scale and administered on paper.

Setting:

The study took place in a Level-II trauma center and the surrounding urban and rural community.

Sample:

This was a convenience sample of 65 adults (age 18 and older), consisting of 32 registered nurses and 33 non-nurse residents of the community.

Procedures:

While a panel of hospital experts had initially evaluated the content of the educational handout, this survey specifically targeted input from consumers. The survey asked respondents to rate the brochure’s ease of understanding, reading ease, usefulness, amount of information, and an overall rating. Likert scale ratings ranged from strongly disagree (1) to strongly agree (4). The survey’s Flesch-Kincaid reading grade level was 6.2. The survey and an introductory cover letter were distributed to 2 groups of adults: 1) Nurses from the Level-II trauma center, and 2) Non-nurse adult community residents. Participants were asked to review the brochure, complete the anonymous survey, and return it in a stamped, self-addressed envelope (SASE).

Findings/Results:

Of the 65 surveys returned, 32 were registered nurses and 33 were non-nurses. As this was the final step in creating a consumer-friendly educational product, the investigators aimed for a cross-section of opinions from the population that included a range of ages among nurses and non-nurses and a sample of both anticoagulated and non-anticoagulated persons. Five study participants (7.7%) were taking anticoagulation medications. The non-nurses were significantly older than the nurses (p=.001), with mean age 53.3 years (¬±SD 18.5) compared to 40.0 years (¬±SD 9.4) for non-nurses. Age ranged from 22 to 92. Ratings of the 8 items were consistently very positive, with mean scores for each survey item ranging from 3.409 to 3.906, out of a possible score of 4.0. The item ratings did not differ by group (nurses/ non-nurses), with all p-values >0.05. The mean score of the overall rating item was 3.613 (¬±SD 0.56) for nurses as compared to 3.788 (¬±SD 0.42) for non-nurses, p=0.163.

Discussion/Conclusions/Implications:

This survey was useful in validating the content, readability, and acceptance of an educational product prior to public dissemination. The results verified that consumers in our sample found the educational material to be understandable and readable, with the right amount of information. Public education gains importance as the elderly demographic and the number of anticoagulated patients in the population increases. Survey sampling should not be overlooked by trauma centers as they embark on public education initiatives, in an effort to produce easy-to-read materials with meaningful content.

Research-R10

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Rehydration Therapy in Children: Recombinant Human Hyaluronidase-Facilitated Subcutaneous vs Intravenous Administration

Authors:

Philip R. Spandorfer, MD, MSCE; Harold K. Simon, MD; and George Harb, MD, MPH

Background & Purpose:

Establishing intravenous (IV) access can be difficult in children, who often have small veins. The purpose of the Increased Flow Utilizing Subcutaneously-Enabled Pediatric Rehydration II (INFUSE-Peds II) study is to evaluate the safety and efficacy of recombinant human hyaluronidase (rHuPH20)-facilitated subcutaneous (SC) vs IV fluid administration, in children with mild to moderate dehydration.

Study/Project Design:

Ongoing, Phase IV, randomized, open-label, non-inferiority, company-sponsored, clinical trial.

Setting:

This multicenter trial is being conducted in patients presenting to emergency departments.

Sample:

Subjects are otherwise healthy children aged 1 month to 10 years with mild to moderate dehydration (Gorelick scores of 1 to 6).

Procedures:

Patients are randomized to treatment groups (SC or IV), stratified based on baseline body weight and dehydration severity. Patients receive 20 mL/kg isotonic fluid over 1 hr and additional fluid, as needed, until clinically rehydrated up to 72 hrs, via SC or IV administration. The primary end point is total fluid volume administered at a single infusion site. Secondary end points include dehydration symptoms, dehydration score, ease of use outcomes, and safety evaluations, including adverse events (AEs).

Findings/Results:

Interim analysis is reported on 74 patients (37 SC, 37 IV), mean age 1.98 years (¬±1.56). Mean volume infused was 374 mL (¬±292.1) SC vs 491 mL (¬±645.3) IV, and 445 mL SC vs 419 mL IV when adjusted for duration. Mean improvement in dehydration score was -2.8 (-3.2, -2.4) SC and -2.4 (-3.0, -1.8) IV; mean weight change was +0.3 kg (+0.2, +0.4) in both groups. Initial catheter placement was successful in 97% SC vs 49% IV (OR=38.0; 4.7-306.9). Catheter placement failed in 0/37 SC vs 8/37 IV patients; median placement time was 0.6 min (0.25, 0.92) SC vs 5.0 min (1.0, 9.92) IV. AEs (SC, IV) were mild to moderate: pain (73%, 86%), erythema (73%, 6.9%), swelling (80%, 0%), and extravasation (0%, 3%).

Discussion/Conclusions/Implications:

Preliminary results reveal that rHuPH20-facilitated SC infusions were generally safe and well tolerated. Duration-adjusted mean volume of fluids and resolution of dehydration were comparable for both routes of administration. In these patients, catheter placement was quicker and more often successful with SC than IV. The SC route may represent an acceptable alternative to IV for non-bolus isotonic fluid administration in patients with failed or difficult IV access, until a more definitive route of access can be obtained.

Research-R11

Oral Presentation – Concurrent Session – Thursday, April 8, 2010 – 9:15-10:15AM

Abstract Title:

Seatbelt Compliance: Is Obesity a Factor?

Authors:

Amber Kyle, BSN, RN and Terri Gillespie, BSN, RN

Background & Purpose:

Mississippi leads the nation with the highest rate of obesity, accidental deaths, and seatbelt non-compliance. The purpose of this study was to determine if obese patients are less likely to wear their seatbelt compared to normal weight and over weight patients involved in motor vehicle collisions and how mortality rates were affected by the rate of non-compliance.

Study/Project Design:

This was a retrospective review of trauma registry data.

Setting:

Academic medical center and Level 1 Trauma Center.

Sample:

This was a convenience sample of 1302 adult patients (>=16 years of age) cared for over a 2 1/2 year period (January 2007-July 2009).

Procedures:

De-identified trauma registry data was collected for those patients (>=16 years of age) involved in motor vehicle collisions. The data collected included weight, height, documented restraint type, and patient outcome. Body mass index was calculated using the weight divided by the height squared. Body mass index of 18-24.9 were classified as normal weight, 25-29.9 were classified as over weight, and >30 were classified as obese.

Findings/Results:

Results of a Chi-square test indicated a significant association between seatbelt use and weight category, p=0.001. Sixty-two percent of obese patients were compliant with wearing a seatbelt compared to over weight patients with a compliance rate of 53.9%, and normal weight patients with a compliance of 48.9%. Bonferron-corrected pairwise comparisons of weight categories indicated that the persons in the obese category had a significantly higher compliance rate compared to the compliance rates of those in the over weight and normal weight categories. Mortality rate for restrained obese patients was at 2.1% compared to normal weight and over weight patients which were at 0.9% and 3.0% respectively. In the group of unrestrained patients, obese patients had the hightest mortality rate which was 6.2% compared to normal weight and over weight patients which were 4.5% and 4.7% respectively.

Discussion/Conclusions/Implications:

Obese patients involved in motor vehicle collisions were significantly more likely to be restrained than normal or over weight patients. Restrained obese patients had the lowest mortality rate. However, among those unrestrained, mortality was 40% higher in the obese group than in the normal or over weight groups. Further research is needed to look at complication rates, cost, and hospital length of stay among these three weight groups, and the restraint usage among these weight groups of patients pronounced dead at the scene.

Research-R12

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

The Silo Effect of a Trauma System in a Level I Trauma Center

Authors:

Daneen Mace-Vadjunec, RN, BSN; M. Ben Melnykovich, RN, BSAS; Barbara M. Hileman, BA; and Jill E. Little, BA

Background & Purpose:

The silo effect is the lack of common goals and communication between departments of an organization, reflecting the inability of departments to work as a team. Trauma care produces better results when the individual departments work cohesively. It is a collaborative effort of many disciplines who work together to provide the best care for the patient regardless of their area of expertise.

Study/Project Design:

Trauma system employees with direct patient care were prospectively surveyed.

Setting:

St. Elizabeth Health Center, a Level I Trauma Center, located in Youngstown, Ohio.

Sample:

Of the 1155 employees with direct patient contact, 697 responded to the surveys, which is a 60% response rate.

Procedures:

This study assessed the employee‚Äôs perception of intra and interdepartmental relationships of the trauma system units. Surveys were administered to all employees with direct patient contact, who work within the trauma system. The surveys were anonymous to encourage more honest responses and only the research staff viewed individual results. Departments were divided into two categories, those who work directly with trauma patients on a regular basis and those whose units are peripherally involved, only occasionally caring for trauma patients. The information gathered included: demographic data, length of employment, occupation, intra and interdepartmental knowledge/relations, and general knowledge of the trauma system. SPSS was used for descriptive analysis and significance testing.

Findings/Results:

Of the respondents, 79% were female, 20% male; mean length of time at the hospital = 10.9yrs; 63% were professional positions, 27% technical, and 8% physician/extender. Intradepartmental relations were good (93% aware of other's roles, 70% familiar with co-workers skills, 89% good team work, 92% intra-unit pride, 53% good communication, 90% openly collaborate). Interdepartmental relations were not as good (51% communicate well with other units, 28% other units communicate well with theirs, 78% openly collaborate with other units, 59% respected by other units). Of those peripherally involved with trauma, fewer considered their position part of the trauma system, more felt they were not part of it, and more were not proud to be part of it (90%, 84%, 83% respectively; all $p<0.001$). They were also more likely to think the patient ceased being a trauma before discharge, feel less respected by trauma, and say no to aiding other units in trauma care (82%, 61%, 71% respectively; all $p<0.05$).

Discussion/Conclusions/Implications:

Trauma care, once the surgeon's territory, is a team effort, beginning at roadside and continuing through rehabilitation. Those who are more directly involved with trauma patients were overall, more engaged in the trauma system than the employees who work in areas less involved with trauma patients. Also, intradepartmental relationships were much stronger than interdepartmental relationships, indicating the silo effect truly exists within the trauma system. To encourage more of a team atmosphere, an effort should be made to engage the peripherally involved departments with the trauma system.

Research-R13

Poster – Available for viewing beginning 11:00AM Thursday, April 8, 2010 until 1:30PM Friday, April 9, 2010

Abstract Title:

Unplanned Extubations in Trauma-related Intensive Care Units

Authors:

Heather Kulp, BSN, MPH; Ercele Reyes, RN, MSN; and Michael Lloyd, RN, MS

Background & Purpose:

Sedation and restraints are often used in ICU settings to prevent unplanned extubations. Few have proven that both sedation and restraint use decrease unplanned extubation. As part of our performance improvement, we set out to monitor unplanned extubations (UE) and determine what factors contribute to UE. We hypothesized that sedation and restraints alone would not prevent UE in trauma patients.

Study/Project Design:

This was a prospective observational study.

Setting:

Level 1 trauma accredited urban hospital, ED, PACU, SICU, BICU, NSICU, NICU.

Sample:

All intubated trauma injured patients admitted to any one of our trauma-related units.

Procedures:

We prospectively collected data on all intubated patients in our ED, PACU, SICU, BICU, NSICU and NICU beginning in 2007 and continue to concurrently monitor them. We collected the following data on these patients- Ramsey score, appropriate sedation, re-intubation, face mask used for 24 hours post-extubation, restraint use and accidental or positional extubation.

Findings/Results:

Rates of unplanned extubations are reported between 0.7% and 25%. We found 110 self-extubations in nearly 3 years, with a rate of 1.6% per yea. Of those only 43% had appropriate sedation, yet 82% were restrained at time of extubation. Nearly 60% of patients did not require re-intubation. Our results show that sedation alone is not enough to prevent unplanned extubations, both sedation and restraints are needed to prevent extubation. We also found that the Ramsey score used as a tool to monitor sedation during the study period was not effective at predicting extubation.

Discussion/Conclusions/Implications:

Given our high number of patients that did not require re-intubation, we have since updated our ventilator weaning protocols. We have also changed from the Ramsey score to the Richmond Agitation-Sedation Scale (RASS). The RASS is more reliable and valid in ICU settings and also incorporates many medical disciplines, such as nursing and pharmacy. Our model of performance improvement in unplanned extubations is now being used in all ICU settings within the hospital.

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GET INVOLVED!

As you already know, some of the best rewards from joining the Society of Trauma Nurses are networking and relationship building. There are many ways to maximize your membership in STN, but an investment of time and effort in activities is essential. STN provides a number of opportunities for you to **GET INVOLVED**—some activities require little time while others take a bigger commitment. Shift to the gear that works best for **you**.

For more information about how you can participate, contact STN at 859-977-7456 or email info@traumanurses.org. You can also find beneficial information at www.traumanurses.org.

1st GEAR

(requires the least time)

Voting

Participating in List Serve

Answering Surveys

Posting Journal Articles at Work

Writing Letters to Legislators in Support of STN / Trauma Issues

Attend STN Annual Conference

Membership Recruitment

Member Appreciation/Acknowledgement

2nd GEAR

State Chair

Active Committee Member

Active SIG Member

JTN Manuscript Reviewer

Ad Hoc Committees *(such as Nominating Committee and Awards Committee)*

3rd GEAR

Committee Chair

ATCN Faculty

Active Member of a Special Project *(developing new courses, educational tools, etc.)*

Submit Abstract to Annual Conference

Submit Manuscript to JTN

Annual Conference Committee

Conference Presenter

Region Chair

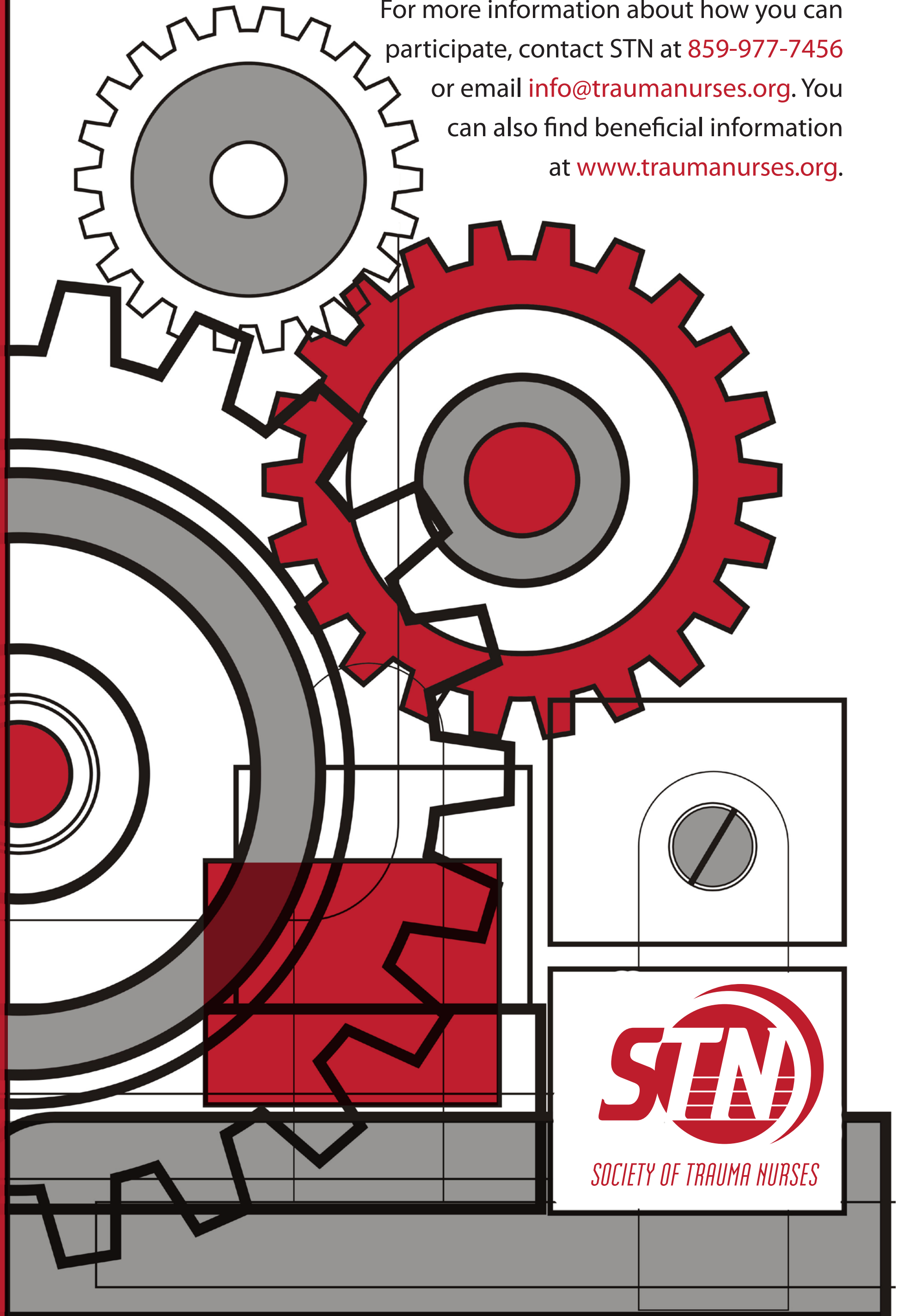
4th GEAR

(requires the most time)

STN Board of Directors

ATCN Executive Committee

ATCN International Chair



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