ENAConnection

VOLUME 47, ISSUE 2 MARCH 2023

UAE Cultural Exchange

The Nuances of Nursing in the United Arab Emirates

GOING ABOVE & BEYOND

The Importance of Trauma-Informed Care for Effective Healing

DIFFERENCE MAKER

Nisreen Atta Embarks on Journey as Emerging Professional Liaison

FOR ADULTS WITH SCHIZOPHRENIA
OR BIPOLAR I OR II DISORDER,

LET'S FIND COMMON GROUND IN THE TREATMENT OF AGITATION

Not an actual patient or healthcare provider.

IGALMI is a sublingual film purposefully designed to support a cooperative approach to agitation intervention[1,2]

INDICATION

IGALMI is indicated for the acute treatment of agitation associated with schizophrenia or bipolar I or II disorder in adults. **Limitations of Use: The safety and effectiveness of IGALMI have not been established beyond 24 hours from the first dose.**

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hypotension, Orthostatic Hypotension, and Bradycardia: IGALMI causes dose-dependent hypotension, orthostatic hypotension, and bradycardia. In clinical studies with IGALMI, patients were excluded if they had treatment with alpha-1 noradrenergic blockers, benzodiazepines, other hypnotics or antipsychotic drugs four hours prior to study drug administration; had a history of syncope or syncopal attacks; SBP < 110 mmHg; DBP < 70 mmHg; HR < 55 beats per minute; or had evidence of hypovolemia or orthostatic hypotension. Because IGALMI decreases sympathetic nervous system activity, hypotension and/or bradycardia may be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension, and in geriatric patients. Avoid use of IGALMI in patients with hypotension, orthostatic hypotension, advanced heart block, severe ventricular dysfunction, or history of syncope. After IGALMI administration, patients should be adequately hydrated and should sit or lie down until vital signs are within normal range. If a patient is unable to remain seated or lying down, precautions should be taken to reduce the risk of falls. Ensure that a patient is alert and not experiencing orthostatic hypotension or symptomatic hypotension prior to allowing them to resume ambulation.

QT Interval Prolongation: IGALMI prolongs the QT interval. Avoid use of IGALMI in patients at risk of torsades de pointes or sudden death, including those with known QT prolongation, a history of other arrhythmias, symptomatic bradycardia, hypokalemia, or hypomagnesemia, and in patients receiving other drugs known to prolong the QT interval.

Somnolence: IGALMI can cause somnolence. Patients should not perform activities requiring mental alertness, such as operating a motor vehicle or operating hazardous machinery, for at least eight hours after taking IGALMI.

Risk of Withdrawal Reactions, Tolerance, and Tachyphylaxis: IGALMI was not studied for longer than 24 hours after the first dose. There may be a risk of physical dependence, a withdrawal syndrome, tolerance, and/or tachyphylaxis if IGALMI is used in a manner other than indicated.

IGALMI IS THE FIRST AND ONLY SUBLINGUAL FILM FORMULATION OF DEXMEDETOMIDINE

Igalmi™
(dexmedetomidine)
sublingual film · 120 mcg, 180 mcg

- **TARGETS** a key mediator of agitation[1,3,4]*
- **NONINVASIVE** sublingual film with a mucoadhesive design, so it cannot be spit out[1,4]
- **PATIENT ADMINISTERED** under the supervision of a healthcare provider[1]

Learn more about the proven reduction in agitation related to schizophrenia and bipolar I or II disorder at IGALMIhcp.com

*IGALMI reduces the release of norepinephrine, a key mediator among other neurotransmitters thought to be involved in agitation.[1,3,4]

IMPORTANT SAFETY INFORMATION (continued)

ADVERSE REACTIONS

The most common adverse reactions (incidence ≥5% and at least twice the rate of placebo) were somnolence, oral paresthesia or oral hypoesthesia, dizziness, dry mouth, hypotension, and orthostatic hypotension.

DRUG INTERACTIONS

Drugs That Prolong the QT Interval: Avoid use. Concomitant use of drugs that prolong the QT interval may add to the QT-prolonging effects of IGALMI and increase the risk of cardiac arrhythmia.

Anesthetics, Sedatives, Hypnotics, and Opioids: Concomitant use may cause enhanced CNS-depressant effects. Reduction in dosage of IGALMI or the concomitant medication should be considered.

USE IN SPECIFIC POPULATIONS

Hepatic Impairment and Geriatric Patients (≥65 years old): A lower dose is recommended in patients with hepatic impairment and geriatric patients. See the full Prescribing Information for the recommended dosage depending on the agitation severity.

Please see the Brief Summary of the full Prescribing Information on the following pages.

To report SUSPECTED ADVERSE REACTIONS, contact BioXcel Therapeutics, Inc. at 1-833-201-1088 or medinfo@bioxceltherapeutics.com, or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

References: 1. IGALMI. Package insert. BioXcel Therapeutics, Inc.; 2022. **2.** Wilson MP, et al. *West J Emerg Med*. 2012;13(1):26-34. doi:10.5811/westjem.2011.9.6866 **3.** Miller CWT, et al. *West J Emerg Med*. 2020;21(4):841-848. doi:10.5811/westjem.2020.4.45779 **4.** Data on file. BXCL501-301 CSR (SERENITY I). BioXcel Therapeutics, Inc.; January 2021.

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bioxcel therapeutics®

Igalmi™
(dexmedetomidine)
sublingual film · 120 mcg, 180 mcg

IGALMI™ (dexmedetomidine) sublingual film, for sublingual or buccal use. Rx Only. Brief Summary of Prescribing Information (PI) for IGALMI. See full PI.

Indication: IGALMI is indicated for the acute treatment of agitation associated with schizophrenia or bipolar I or II disorder in adults. Limitations of Use: The safety and effectiveness of IGALMI have not been established beyond 24 hours from the first dose.

Important Recommendations Prior to Initiating IGALMI and During Therapy: IGALMI should be administered under the supervision of a healthcare provider. A healthcare provider should monitor vital signs and alertness after IGALMI administration to prevent falls and syncope.

IGALMI is for sublingual or buccal administration. Do not chew or swallow IGALMI. Do not eat or drink for at least 15 minutes after sublingual administration, or at least one hour after buccal administration.

Recommended Dosage: The initial dose of IGALMI is based on agitation severity, with lower doses recommended in patients with hepatic impairment and geriatric patients. If agitation persists after the initial dose, up to two additional doses may be administered at least two hours apart, depending upon the patient population and agitation severity. Assess vital signs including orthostatic measurements prior to the administration of any subsequent doses. Due to risk of hypotension, additional half-doses are not recommended in patients with systolic blood pressure (SBP) less than 90 mmHg, diastolic blood pressure (DBP) less than 60 mmHg, heart rate (HR) less than 60 beats per minute, or postural decrease in SBP ≥ 20 mmHg or in DBP ≥ 10 mmHg.

The recommended dose in adults is 120 mcg for mild or moderate agitation and 180 mcg for severe agitation. Patients with mild or moderate hepatic impairment and mild to moderate agitation should receive 90 mcg. Patients with mild or moderate hepatic impairment and severe agitation should receive 120 mcg. Patients with severe hepatic impairment and mild to moderate agitation should receive 60 mcg. Patients with severe hepatic impairment and severe agitation should receive 90 mcg. Geriatric patients (patients ≥65 years old) with mild, moderate or severe agitation should receive 120 mcg. See Full Prescribing Information for recommendations on administering up to two additional doses and maximum recommended dosages.

CONTRAINDICATIONS: None.

WARNINGS AND PRECAUTIONS

Hypotension, Orthostatic Hypotension, and Bradycardia: IGALMI causes dose-dependent hypotension, orthostatic hypotension, and bradycardia. In clinical studies, 18%, 16%, and 9% of patients treated with 180 mcg of IGALMI, 120 mcg of IGALMI, and placebo, respectively, experienced orthostatic hypotension (defined as SBP decrease ≥ 20 mmHg or DBP decrease ≥ 10 mmHg after 1, 3, or 5 minutes of standing) at 2 hours post-dose. In those studies, 7%, 6%, and 1% of patients treated with 180 mcg of IGALMI, 120 mcg of IGALMI, and placebo, respectively, experienced HR ≤ 50 beats per minute within 2 hours of dosing. In clinical studies with IGALMI, patients were excluded if they had treatment with alpha-1 noradrenergic blockers, benzodiazepines, other hypnotics or antipsychotic drugs four hours prior to study drug administration; had a history of syncope or syncopal attacks; SBP < 110 mmHg; DBP < 70 mmHg; HR < 55 beats per minute; or had evidence of hypovolemia or orthostatic hypotension.

Reports of hypotension and bradycardia, including some resulting in fatalities, have been associated with the use of another dexmedetomidine product given intravenously (IGALMI is for sublingual or buccal use and is not approved for intravenous use). Clinically significant episodes of bradycardia and sinus arrest have been reported after administration of this other dexmedetomidine product to young, healthy adult volunteers with high vagal tone and when this product was given by rapid intravenous or bolus administration.

Because IGALMI decreases sympathetic nervous system activity, hypotension and/or bradycardia may be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension, and in geriatric patients. Avoid use of IGALMI in patients with hypotension, orthostatic hypotension, advanced heart block, severe ventricular dysfunction, or history of syncope. After IGALMI administration, patients should be adequately hydrated and should sit or lie down until vital signs are within normal range. If a patient is unable to remain seated or lying down, precautions should be taken to reduce the risk of falls. Ensure that a patient is alert and not experiencing orthostatic hypotension or symptomatic hypotension prior to allowing them to resume ambulation.

QT Interval Prolongation: IGALMI prolongs the QT interval. Avoid use of IGALMI in patients at risk of torsades de pointes or sudden death including those with known QT prolongation, a history of other arrhythmias, symptomatic bradycardia, hypokalemia or hypomagnesemia, and in patients receiving other drugs known to prolong the QT interval.

Somnolence: IGALMI can cause somnolence. In placebo-controlled clinical studies in adults with agitation associated with schizophrenia or bipolar I or II disorder, somnolence (including fatigue and sluggishness) was reported in 23% and 22% of patients treated with IGALMI 180 mcg and 120 mcg, respectively, compared to 6% of placebo-treated patients. Patients should not perform activities requiring mental alertness, such as operating a motor vehicle or operating hazardous machinery, for at least eight hours after taking IGALMI.

Risk of Withdrawal Reactions: Symptoms of withdrawal have been observed after procedural sedation with another dexmedetomidine product administered intravenously. In this study, 12 (5%) adult patients who received intravenous dexmedetomidine up to 7 days (regardless of dose) experienced at least 1 event related to withdrawal within the first 24 hours after discontinuing dexmedetomidine and 7 (3%) adult patients who received intravenous dexmedetomidine experienced at least 1 event related with withdrawal 24 to 48 hours after discontinuing dexmedetomidine. The most common withdrawal reactions were nausea, vomiting, and agitation. In these subjects, tachycardia and hypertension requiring intervention occurred at a frequency of <5% in the 48 hours following intravenous dexmedetomidine discontinuation. IGALMI was not studied for longer than 24 hours after the first dose. There may be a risk of physical dependence and a withdrawal syndrome if IGALMI is used in a manner other than indicated.

Tolerance and Tachyphylaxis: Use of another dexmedetomidine product administered intravenously beyond 24 hours has been associated with tolerance and tachyphylaxis and a dose-related increase in adverse reactions. IGALMI was not studied for longer than 24 hours after the first dose. There may be a risk of tolerance and tachyphylaxis if IGALMI is used in a manner other than indicated.

ADVERSE REACTIONS, Clinical Studies Experience: Because clinical trials are conducted under widely varying conditions, adverse reactions rates observed in the clinical trials of a drug cannot be directly compared to rates in clinical trials of another drug and may not reflect the rates observed in practice.

The safety of IGALMI was evaluated in 507 adult patients with agitation associated with schizophrenia (N=255) or bipolar I or II disorder (N=252) in two randomized, placebo-controlled studies (Studies 1 and 2). In both studies, patients were admitted to a clinical research unit or a hospital and remained under medical supervision for at least 24 hours following treatment. Patients were 18 to 71 years of age (mean age was 46 years old); 45% were female and 55% were male; 66% were Black, 31% were White, 2% were multiracial, and 1% were other.

In these studies, patients received an initial dose of IGALMI 180 mcg (N=252), IGALMI 120 mcg (N=255), or placebo (N=252). Patients who were hemodynamically stable (i.e., those with systolic blood pressure (SBP) > 90 mmHg, diastolic blood pressure (DBP) > 60 mmHg, and heart rate (HR) > 60 beats per minute) and without orthostatic hypotension (i.e., reduction in SBP < 20 mmHg or DBP < 10 mmHg upon standing) were eligible for an additional dose after 2 hours. An additional half dose (90 mcg, 60 mcg, or placebo) was given to 7.1% (18/252), 22.7% (58/255) and 44.0% (111/252) of patients in the IGALMI 180 mcg, IGALMI 120 mcg or placebo arms, respectively. After at least an additional 2 hours, an additional second half dose (total IGALMI dose of 360 mcg, total IGALMI dose of 240 mcg, or placebo, respectively) was given to 3.2% (8/252), 9.4% (24/255), and 21.0% (53/252) of patients in the IGALMI 180 mcg, IGALMI 120 mcg or placebo arms, respectively.

In these studies, one patient discontinued treatment due to an adverse reaction of oropharyngeal pain.

The most common adverse reactions (incidence ≥ 5% and at least twice the rate of placebo) were: somnolence, oral paresthesia or oral hypoesthesia, dizziness, dry mouth, hypotension, and orthostatic hypotension.

Adverse reactions that occurred in IGALMI-treated patients at a rate of at least 2% and at a higher rate than in placebo-treated patients in Studies 1 and 2 were as follows (adverse reaction is followed by percentage of patients treated with IGALMI 180 mcg (n = 252), IGALMI 120 mcg (n = 255) and placebo (n = 252): Somnolence, includes the terms fatigue and sluggishness, (23%, 22%, 6%); Oral paresthesia or oral hypoesthesia (7%, 6%, 1%); Dizziness (6%, 4%, 1%); Hypotension (5%, 5%, 0%); Orthostatic hypotension (5%, 3%, <1%); Dry Mouth (4%, 7%, 1%); Nausea (3%, 2%, 2%); Bradycardia (2%, 2%, 0%); Abdominal discomfort, including dyspepsia, gastroesophageal reflux disease (2%, 0%, 1%).

Hypotension, Orthostatic Hypotension, and Bradycardia in Two Placebo-Controlled Studies: In clinical studies, patients were excluded if they were treated with alpha-1 noradrenergic blockers, benzodiazepines, antipsychotic drugs, or other hypnotics four hours prior to study drug administration; had a history of syncope or syncopal attacks; their SBP was less than 110 mmHg; their DBP was less than 70 mmHg; their HR was less than 55 beats per minute; or they had evidence of hypovolemia or orthostatic hypotension. In these studies, vital signs were monitored (at 30 minutes, 1-, 2-, 4-, 6-, and 8- hours post-dose), including orthostatic vital signs at 2-, 4-, and 8-hours post-dose. Maximum positional decreases in SBP and DBP after standing were observed at two hours post-dose. Maximal reductions on BP and HR were observed two hours post-dose.

The mean BP (in mmHg) and HR decrease (in bpm) across all patients from both studies at 2 hours post-dose were as follows for patients treated with IGALMI 180 mcg (n = 252), IGALMI 120 mcg (n = 255) and placebo (n = 252): Mean SBP Decrease (15, 13, 1), Mean DBP Decrease (mmHg) (8, 7, <1), Mean Heart Rate Decrease (9, 7, 3). In the clinical studies: 13%, 8%, and <1% of patients in the single dose 180 mcg IGALMI, 120 mcg IGALMI, and placebo groups, respectively, experienced SBP ≤ 90 mmHg and a decrease ≥ 20 mmHg of SBP within 24 hours of dosing; 19%, 17%, and 2% of the patients in the 180 mcg IGALMI, 120 mcg IGALMI, and placebo groups, respectively, had a DBP ≤ 60 mmHg and a DBP decrease ≥ 10 mmHg within 24 hours of dosing; 4%, 3%, and 0% of patients in the 180 mcg IGALMI, 120 mcg IGALMI, and placebo groups, respectively, had a HR ≤ 50 beats per minute and a HR decrease ≥ 20 beats per minute within 24 hours of dosing.

At 8 hours post-dose, 2% of patients in the IGALMI 180 mcg group experienced a SBP ≤ 90 mmHg and decrease ≥ 20 mmHg compared with one patient (<1%) in the IGALMI 120 mcg group and none in the placebo group. At 24 hours, none of the patients in the IGALMI 180 mcg group experienced a SBP ≤90 mmHg and decrease ≥ 20 mmHg compared with one patient (<1%) in the IGALMI 120 mcg group and none in the placebo group. At 8 hours post-dose, none of the patients in the IGALMI 180 mcg group had a HR ≤ 50 beats per minute and a HR decrease ≥ 20 beats per minute compared with one patient in the 120 mcg group (<1%) and none in the placebo group.

Postmarketing Experience

The following adverse reactions have been identified during post approval use of another dexmedetomidine product given intravenously (IGALMI is not approved for intravenous use). Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Blood and Lymphatic System Disorders: Anemia; *Cardiac Disorders:* Arrhythmia, atrial fibrillation, atrioventricular block, bradycardia, cardiac arrest, cardiac disorder, extrasystoles, myocardial infarction, supraventricular tachycardia, tachycardia, ventricular arrhythmia, ventricular tachycardia; *Eye Disorders:* Photopsia, visual impairment; *Gastrointestinal Disorders:* Abdominal pain, diarrhea, nausea, vomiting; *General Disorders and Administration Site Conditions:* Chills, hyperpyrexia, pain, pyrexia, thirst; Hepatobiliary Disorders: Hepatic function abnormal, hyperbilirubinemia; Investigations: Alanine aminotransferase increased, aspartate aminotransferase increased, blood alkaline phosphatase increased, blood urea increased, electrocardiogram T wave inversion, gammaglutamyltransferase increased, electrocardiogram QT prolonged; *Metabolism and Nutrition Disorders:* Acidosis, hyperkalemia, hypoglycemia, hypovolemia, hypernatremia; *Nervous System Disorders:* Convulsion, dizziness, headache, neuralgia, neuritis, speech disorder; *Psychiatric Disorders:* Agitation, confusional state, delirium, hallucination, illusion; *Renal and Urinary Disorders:* Oliguria, polyuria; *Respiratory, Thoracic and Mediastinal Disorders:* Apnea, bronchospasm, dyspnea, hypercapnia, hypoventilation, hypoxia, pulmonary congestion, respiratory acidosis; *Skin and Subcutaneous Tissue Disorders:* Hyperhidrosis, pruritus, rash, urticaria; *Surgical and Medical Procedures:* Light anesthesia;

Vascular Disorders: Blood pressure fluctuation, hemorrhage, hypertension, hypotension

DRUG INTERACTIONS

Drugs that Prolong the QT Interval: Concomitant use of drugs that prolong the QT interval may add to the QT-prolonging effects of IGALMI and increase the risk of cardiac arrhythmia. Avoid the use of IGALMI in combination with other drugs known to prolong the QT interval.

Anesthetics, Sedatives, Hypnotics, and Opioids: Concomitant use of IGALMI with anesthetics, sedatives, hypnotics, or opioids is likely to lead to enhanced CNS depressant effects. Specific studies with another dexmedetomidine product given intravenously have confirmed these effects with sevoflurane, isoflurane, propofol, alfentanil, and midazolam. Due to possible enhanced CNS effects when given concomitantly with IGALMI, consider a reduction in dosage of IGALMI or the concomitant anesthetic, sedative, hypnotic, or opioid.

USE IN SPECIFIC POPULATIONS

Pregnancy, Risk Summary: There are no available data on IGALMI use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal effects. Available data from published randomized controlled trials and case reports over several decades of use with intravenously administered dexmedetomidine during pregnancy have not identified a drug-associated risk of major birth defects or miscarriage; however, the reported exposures occurred after the first trimester. Most of the available data are based on studies with exposures that occurred at the time of cesarean-section delivery, and these studies have not identified an adverse effect on maternal outcomes or infant Apgar scores. Available data indicate that dexmedetomidine crosses the placenta.

In animal reproductive studies fetal toxicity occurred in the presence of maternal toxicity with subcutaneous administration of dexmedetomidine to pregnant rats during organogenesis at doses 5 times the maximum recommended human dose [MRHD] of 360 mcg/day based on mg/m^2 body surface area. Adverse developmental effects, including early implantation loss and decreased viability of second generation offspring, occurred when pregnant rats were subcutaneously administered doses less than or equal to the MRHD based on mg/m^2 from late pregnancy through lactation and weaning *(see Data)*.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

Data: *Animal Data*: Increased post-implantation losses and reduced live pups in the presence of maternal toxicity (decreased body weight) occurred in a rat embryo-fetal development study in which pregnant dams were administered subcutaneous doses of dexmedetomidine of 200 mcg/kg/day (equivalent to 5 times the MRHD of 360 mcg/day based on mg/m^2) during the period of organogenesis (Gestation Day (GD) 5 to 16). No embryo-fetal toxicity was observed at 20 mcg/kg/day (less than the MRHD of 360 mcg/day based on mg/m^2). No malformations were reported at any dose level.

No malformation or embryo-fetal toxicity were observed in a rabbit embryo-fetal developmental study in which pregnant dams were administered dexmedetomidine intravenously at doses up to 96 mcg/kg/day (equivalent to 5 times the MRHD of 360 mcg/day based on mg/m^2) during the period of organogenesis (GD 6 to 18).

Reduced pup and adult offspring weights and grip strength were reported in a rat developmental toxicology study in which pregnant females were administered dexmedetomidine subcutaneously at 8 mcg/kg/day (less than the MRHD of 360 mcg/day based on mg/m^2) during late pregnancy through lactation and weaning (GD 16 to postnatal day [PND] 25). Decreased viability of second generation offspring and an increase in early implantation loss along with delayed motor development occurred at 32 mcg/kg/day (equivalent to the MRHD of 360 mcg/day based on mg/m^2) when first generation offspring were mated. This study limited dosing to hard palate closure (GD 15-18) through weaning instead of standard dosing from implantation (GD 6-7) to weaning (PND 21).

Lactation, *Risk Summary*: Available published literature report the presence of dexmedetomidine in human milk following intravenous administration. There is no information regarding the effects of dexmedetomidine on the breastfed child or the effects on milk production. Advise women to monitor the breastfed infant for irritability. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for IGALMI and any potential adverse effects on the breastfed child from IGALMI or from the underlying maternal condition.

Pediatric Use: The safety and effectiveness of IGALMI have not been established in pediatric patients.

Geriatric Use: Fifteen geriatric patients (≥ 65 years of age) were enrolled (no patients were 75 years of age and older) in the clinical studies for acute treatment of agitation associated with schizophrenia or bipolar I or II disorder. Of the total number of IGALMI-treated patients in these clinical studies, 11/507 (2.2%) were 65 years of age and older. Dosage reduction of IGALMI is recommended in geriatric patients. A higher incidence of bradycardia and hypotension was observed in geriatric patients compared to younger adult patients after intravenous administration of another dexmedetomidine product. The pharmacokinetic profile of intravenous dexmedetomidine was not altered in geriatric subjects. Clinical studies of IGALMI did not include sufficient numbers of patients 65 years of age and older to determine whether there were differences in the effectiveness of IGALMI in the acute treatment of agitation associated with schizophrenia or bipolar I or II disorder compared to younger adult patients.

Hepatic Impairment: Dexmedetomidine clearance was decreased in patients with hepatic impairment (Child-Pugh Class A, B, or C). Thus, a dosage reduction of IGALMI is recommended in patients with hepatic impairment compared to patients with normal hepatic function.

DRUG ABUSE AND DEPENDENCE

Controlled Substance: IGALMI contains dexmedetomidine, which is not a controlled substance.

Dependence, Physical Dependence: Physical dependence is a state that develops as a result of physiological adaptation in response to repeated drug use, manifested by withdrawal signs and symptoms after abrupt discontinuation or a significant dose reduction of a drug. The dependence potential of dexmedetomidine has not been studied in humans. However, because studies in rodents and primates have demonstrated that intravenous dexmedetomidine exhibits pharmacologic actions similar to those of clonidine, it is possible that dexmedetomidine may produce a clonidine-like withdrawal syndrome upon abrupt discontinuation. IGALMI was not studied for longer than 24 hours after the first dose. There may be risk of physical dependence and a withdrawal syndrome if IGALMI is used in a manner other than indicated.

Tolerance: Tolerance is a physiological state characterized by a reduced response to a drug after repeated administration (i.e., a higher dose of a drug is required to produce the same effect that was once obtained at a lower dose). IGALMI has not been studied for longer than 24 hours after the first dose. There may be a risk for tolerance if IGALMI is administered in a manner other than indicated.

OVERDOSAGE: In a tolerability study of intravenous dexmedetomidine in which healthy adult subjects were administered doses at and above the recommended dose of 0.2 to 0.7 mcg/kg/hour, the maximum blood concentration was approximately 13 times the upper boundary of the therapeutic range for the intravenous dexmedetomidine (IGALMI is not approved for intravenous use). The most notable effects observed in two subjects who achieved the highest doses were first degree atrioventricular block and second-degree heart block.

Five adult patients received an overdose of intravenous dexmedetomidine in intensive care unit sedation studies. Two patients who received a 2 mcg/kg loading dose (twice the recommended loading dose) over 10 minutes, experienced bradycardia and/or hypotension. One patient who received a loading intravenous bolus dose of undiluted dexmedetomidine (19.4 mcg/kg), had cardiac arrest from which he was successfully resuscitated.

Consider contacting a Poison Center (1-800-222-1222) or a medical toxicologist for overdosage management recommendations for IGALMI.

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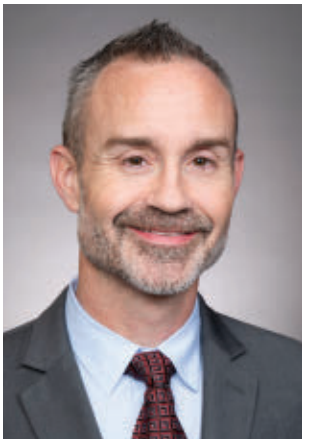
DEPARTMENTS

Cover photo by Lisa Alward

CORRECTION:
An article in the December edition of *ENA Connection* misspelled the name of ENA member Audra Lawlor, ADN, RN.

BE SOCIAL WITH US.

Broadening the Pipeline



By Ryan Oglesby, PhD, MHA, RN, CEN, CFRN, NEA-BC
ENA Secretary/Treasurer

Ralph Waldo Emerson once said, "Our life is much like March weather, savage and serene in one hour." As many of us thaw out from winter and move toward spring, it is comforting to know that no matter how savage our lives have been, and may be in the future, the spring thaw will always provide calm, peace and tranquility.

It is hard to believe we are already three months into 2023. The change in seasons is an opportune time to reflect on the great work ENA is doing for its members, emergency nurses worldwide, and the patients and communities they care for. To sustain this great work, it will be critical for us to continue to reach out and engage those new to the profession. These individuals are essential to our future and our ability to provide safe, effective emergency care.

This year, the ENA Board of Directors, in collaboration with ENA's emerging professional liaison and the Emerging Professional Advisory Council, will need to broaden this reach and engagement even further to secure our future and widen the potential professional pipeline. We are considering various issues to attract and develop the next generation of emergency nurses: What are the new strategies to get young people interested in the profession? Where are the potential emergency nurses of the future? What are the areas of focus we haven't considered yet?

Since 2018, the EPL role has guided and inspired the board on this journey to meeting the demand for emergency care in the future. Individuals in this role have consistently shared their perspectives and key insights on issues relevant to the new nurse in the emergency care setting.

In addition, the EPL engages and supports emerging professionals at all regions and levels of the association. This includes those who may not even know they are interested in exploring the practice of emergency nursing, such as other non-nursing professionals and students.

The EPAC also plays a significant role in addressing issues that emerging professionals face in their career journeys.

This council assesses the needs of emerging professionals and evaluates the solutions necessary to support this group.

The EPAC is also critical in advising ENA on the best channels to communicate and expand engagement with emerging professionals. It plays a valuable role in the recruitment, succession and mentoring opportunities for potential new leaders among those emerging professionals. We are exploring new ways to deepen our reach and widen the funnel for potential emerging professionals, such as visits to EDs, schools and communities to encourage and support individuals to pursue their goals of becoming emergency nurses.

Our 2023 EPL is Nisreen Atta, MSN-Ed, RN, from Wisconsin, whom you will learn more about later in this issue. Nisreen joins the ENA Board of Directors with experience working with multiple under-represented communities and organizations. She is passionate about increasing the diversity of the emergency nursing workforce and is committed to furthering initiatives that will retain and inspire emergency nurses. I have the pleasure of being Nisreen's "board buddy," and she has already become an amazing asset, making a significant impact in the board's discussions and culture. I look forward to everything Nisreen will contribute in the months to come.

I want to thank each and every one of you for your perseverance in the difficult, savage and stormy weather that can cloud our lives at the most unlikely moments as Emerson referenced. Your tenacity and resilience in times of struggle continues to amaze me. We have been able to lean on one another and share peace and calm during the most ferocious of storms, even when we may have felt we had nothing more to give. There is serenity in every storm, and, for many of our patients, your engaging smile, kind words and healing touch may be just that — the calm, peace and tranquility they so desperately need in the midst of their own storms. ●

Get Involved with ENA at the Highest Level!

ENA plays a vital role in shaping the future of emergency nursing, and it takes strong leaders to make that future a successful one. It takes a critical eye to identify, understand and help solve the issues facing emergency nurses.

Two of the most important ways members can contribute to ENA's success and the advancement of the emergency nursing specialty are by taking a leadership role in the organization and offering resolutions for the general assembly to consider.

Be an Emergency Nursing Leader

ENA's leaders are crucial in shaping the association's mission. It's time to discover the next wave of members willing to lend their expertise and experience in an elected ENA leadership position. Become the next ENA leader while enhancing your career and enjoying unprecedented networking opportunities on the ENA Board of Directors or ENA Nominations and Elections Committee. The committee will formally vet and rank the candidates based on a scoring rubric and present a qualified slate of candidates.

ENA's 2023 election candidacy applications will be accepted from April 3 to noon Central time on April 28.

OPEN POSITIONS:

Board of Directors Positions

- 2024 President-elect
- 2024 Secretary/Treasurer
- 2024-2026 Director (two positions)

Nominations and Elections Committee

- Region 1
- Region 3
- Region 5

To learn more about the ENA Board of Directors and the Nominations and Elections Committee — and launch your candidacy — go to **www.ena.org/elections**.

Shape the Conversation at General Assembly

Emergency nurses are uniquely qualified to address the important issues they face every day in the emergency care setting. At General Assembly, ENA affords these nurses the opportunity to influence the association's operational policies and stance on a wide range of issues through resolutions and bylaws amendments.

ENA members are encouraged to develop and submit resolutions now for delegates to consider at the 2023 General Assembly on Sept. 20 and 21 in San Diego.

Proposed resolutions and ENA Bylaws amendments are due by noon Central time on May 23 to *governance@ena.org*.

Members interested in submitting a resolution or proposed bylaws amendment for consideration should work with their ENA Resolutions Committee liaison. More information on the resolution process is available at **www.ena.org/general-assembly**.

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Going Above & Beyond

Trauma-Informed Care Crucial in Effective Healing — and Whether Healing Happens at All

By Laurie Saloman
ENA CONNECTION CONTRIBUTOR

Nurses understand that patients arriving in the emergency department for treatment are often in distress. But tending to the acute injury or illness requires more than just fixing what's wrong or sending the patient for further testing. Proponents of trauma-informed care maintain that the personal interaction between provider and patient emotionally affects the healing that happens — or whether healing occurs at all.

At its core, TIC is based on the idea that trauma is universal. No matter what condition a patient presents to the ED with,

they may have underlying psychological trauma or emotional scars that could be triggered inadvertently by a provider's care approach. According to an April 2022 article in the *American Journal of Nursing*, "[t]raumatic events are those associated with actual or threatened risk of serious injury, death, or sexual violence that are experienced directly, indirectly (by witnessing them), or vicariously (through the experiences of a close friend or loved one)."

Experts maintain that many traumas are more subtle and widespread than is generally realized. According to Natalie Calow, MSN, RN, CEN, AFN-C, a forensic nurse at Indiana University Health Methodist Hospital in Indianapolis and TIC advocate, trauma can include things people might not typically classify as such, like experiencing or witnessing acts of racism or enduring the death of a loved one.

"[TIC] is just an approach to patient care that focuses on a patient's life experiences and the impact this has on patients' health and well-being," she said.

TIC Best Practices

TIC rests on six guiding principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment of voice and choice; and cultural, historical and gender issues.

First, patients need to feel they are safe in the hospital, both physically and emotionally. ED nurses then can help build trust with patients via transparency in their words and actions. By offering patients peer support, nurses help patients see they're not alone in their situations. By partnering with other health care providers, such as physicians, in a collaborative and mutually supportive manner, nurses can ensure that all team members respect the patient's needs and wishes. Empowering patients to voice these needs and wishes also is paramount, as is taking into account how race, gender, sexual orientation, ethnicity and other factors play a role in their experiences.

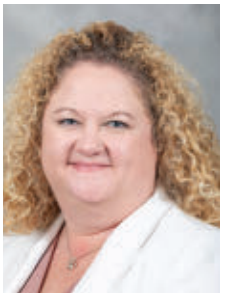
In practice, TIC typically involves sitting at eye level with a patient and gently asking, "What happened to you?" and "Is it OK if I touch you here?" rather than standing over them asking why they're here, Calow said. It's asking the patient what he or she needs to feel safe and comfortable in the moment, perhaps moving the patient from a bustling trauma bay to a more out-of-the-way room with a door that closes. It's reserving judgment and giving patients agency at a time when, because of life experiences, they could feel very powerless.

"We want to make sure they're in a safe environment. We're giving them choices in their care, asking them what triggers them, and acknowledging their cultural beliefs," Calow explained. "This is why every emergency nurse needs to know how to integrate this into their practice."

Trauma and Stress Shape Patients

TIC is crucial because traumatic stress does not occur only during the hours that a patient is in the hospital. It shapes people into who they are and impacts their health trajectories after leaving the ED. According to Calow, people who suffer from poor mental health and chronic stress can be retraumatized during a typical ED visit. They are more likely to feel better about their experiences, follow up with medical

> “We want to make sure they’re in a safe environment. We’re giving them choices in their care, asking them what triggers them, and acknowledging their cultural beliefs. This is why every emergency nurse needs to know how to integrate this into their practice.”
>
> **— Natalie Calow, MSN, RN, CEN CEN, AFN-C**



appointments, and fully engage with their care if they’ve experienced a TIC approach while at the hospital.

Some experts advocate a practice known as trauma- and violence-informed care, which they say builds on TIC and its six bedrock principles.

Christine Foote-Lucero, MSN, RN, CEN, SANE-A, SANE-P, AFN-C

Trauma- and violence-informed care “expands to account for intersecting impacts of systemic and interpersonal violence and structural inequities,” said Christine Foote-Lucero, MSN, RN, CEN, SANE-A, SANE-P, AFN-C, forensic program manager at the University of Colorado Hospital in Aurora. A patient’s past experience with violence might impact his or her ability to process current trauma, she said.

Foote-Lucero offered the example of a sexual assault survivor who arrives at the ED. If there is concern that the patient was exposed to HIV, a nurse practicing TIC would discuss the need for nonoccupational postexposure prophylaxis. A provider practicing TVIC would take it further, asking the patient if he or she can afford nPEP, if he or she has access to a mode of transportation to get to a pharmacy, and whether he or she has ever seen a provider that he or she trusts and feels comfortable going to again.

In the past, before understanding the importance of TIC and TVIC, an ED nurse might have given this patient discharge instructions and a prescription for further medical help or medication, not considering whether the patient would have been able to obtain it.

Like Foote-Lucero, Calow emphasized the importance of respecting the wishes of the patient.

“We frequently see patients who have experienced domestic violence,” she said of her workplace. “They are always being told to do things by their significant other. They never have a choice in their relationship.” The clinical team practicing TIC helps empower those patients to make choices.

Gaps in TIC Education

While TIC and TVIC have come to be recognized as important practices in health care, many nurses have no experience with them. ENA would like to see this change by spearheading educational resources specifically for ED nurses.

Catherine Olson, MSN, RN

ENA Director of Emergency Nursing Practice Excellence Catherine Olson, MSN, RN, is working to add more to ENA’s education in the area.

“They don’t teach the TIC approach in nursing school. Others think it’s just reserved for those in mental health care work or for those in forensics,” Olson said.

Olson and her team plan to lean on subject matter experts — including ENA members and resources from the Substance Abuse and Mental Health Service Administration — to develop resources and tools that can help nurses incorporate TIC principles into their daily practice.

A first step would be for nurses to slow down and engage in active listening with patients. This can be a heavy lift in the typical ED.

When there’s strong operational emphasis on throughput metrics, “it almost forces nurses to focus on that efficiency over spending time with a patient,” Olson said. And with the recent “tripledemic” surges and nursing staffing crisis making matters worse, many ED nurses can get into what Olson calls “assembly-line mode” — just working to get patients in and out of the ED.

Olson’s vision is to start by developing ENA practice resources and possibly a stand-alone course on TIC to be included in ENA University, education that would be targeted specifically to ED nurses as well as those in leadership positions.

“The interconnectedness of ED nurses, from stretcherside to leaders and managers, means a healthy work environment depends on all colleagues understanding and implementing this care model,” she said.

TIC advocates want to stress to ED nurses that incorporating TIC and TVIC into their practices benefits them, not just patients, by helping to recognize and manage secondary traumatic stress. Emergency nurses witness and hold a lot of patients' stress, Calow said. They experience chronic fatigue and burnout, ultimately leading to staff turnover.

Olson agreed, adding, "We are exposed to a lot of trauma in our work. We need to have not only self-awareness but support for our colleagues. Practicing trauma-informed care is needed to support patients as well as individual nurses' well being." ●

Hear more about trauma-informed care from Natalie Calow on the ENA podcast at ***pod.link/ENAPodcast***.

TIC Principles in ENA Flagship Course

The Emergency Nurses Association's Trauma Nursing Core Course, 8th Edition, introduces the psychosocial aspects of trauma-informed care, including the key principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment of voice and choice; and cultural, historical and gender issues.

Measuring DEI

Consultant Helps ENA Quantify Progress on Diversity Efforts

By Shelly Strom

ENA CONNECTION CONTRIBUTOR

As ENA continues its work to combat systemic racism and promote diversity, equity and inclusivity in the specialty, it's now starting to gauge the effectiveness of its efforts.

ENA is collaborating with Nonprofit HR, a leading human resources firm that specializes in helping nonprofits develop DEI strategies that create equitable systems to advance diversity and inclusion in their organizations. The firm led two assessments, each involving surveys sent to members and staff late last year. Although this isn't the first time ENA has surveyed members or staff, it's the first time the association has gathered data broadly on identity. The surveys will help inform how the association promotes DEI and creates new strategies.

This is one of many DEI initiatives ENA has undertaken since the 2020 police killing of George Floyd, which launched ongoing conversations within ENA and around the world about racism, justice and inclusion, said ENA Marketing Specialist Aaron Coats.

Aaron Coats

"Immediately after George Floyd was killed, ENA wanted to be considerate when it came to making a public

statement on racism. And in the months that followed, we also wanted to make clear that we are taking action and not simply making lip service," Coats said.

Setting the Example

Coats is co-chair of a staff council that leads ENA's work toward DEI — sometimes written as DEIJ to reflect efforts to promote justice. ENA also has a volunteer member committee tasked with DEI. The two groups have helped facilitate multiple accomplishments, including DEI training sessions for staff, a webpage featuring DEI resources and a new award recognizing DEI-oriented initiatives by nurses. The association also named the first fellows in its new Emergency Nursing Diverse Voices Research program, which will help amplify the voices of nurses from historically under-represented groups.

"ENA's goal is to be an exemplar of excellence in delivering emergency nursing care, and this work to drive diversity, equity, inclusion and justice is integral in that mission," Coats said.

"We also want to be an example for other organizations seeking how to do this work, and, of course, have a positive impact for the patient population. We hope to provide actionable items for our frontline caregivers in responding to racism and inequality, whether in terms of patient care or in the way they are treated," he said.

Steven Krzanowski

Nonprofit HR plans to present assessment findings to the ENA Board of Directors, staff and members in spring or summer.

"One of the objectives of this first phase is to gain insight and assess what already is being done around DEIJ, identify the challenges and aspirations, and assess what it will take to get there," said Steven Krzanowski, MA, a senior diversity, equity, inclusion and justice consultant with Nonprofit HR.

Creating the Road Map

The staff survey looks closely at practices and experiences in relation to human resources policies, assessing levels of belonging and inclusion. The member survey asked questions about experiences of being a member and interacting with ENA, whether as a consumer of publications, online education, annual conferences or other ways.

Data gathered in this initial round will help inform recommendations to drive work applicable inside the organization, largely relating to ENA's workforce and prospective job candidates, Krzanowski said.

"We look at how the association is showing up, both from an HR and DEIJ perspective by examining the entire employee life cycle for potential bias. We review written and unwritten policies and procedures, including the recruitment and selection processes, onboarding, and ongoing workforce management," he said.

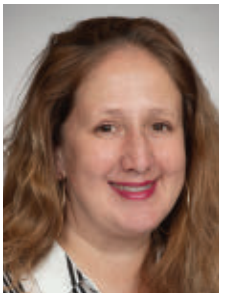
Additional data are being gathered for external-facing DEI efforts relating to members, prospective members and audiences outside the association.

"We're doing an external brand review that includes gauging levels of belonging and the inclusiveness of outward practices and policies," Krzanowski said.

Each data set will serve as benchmarks to track progress and quantify achievement. At the end of the data-collection phase, Nonprofit HR will develop recommendations that will be used

to design a strategic framework that will advance DEI efforts.

The recommendations, Krzanowski said, will be organized around five pillars: transparency, power sharing, operational accountability, people and culture, and systems change.



Altair Delao

Hershaw Davis Jr., MSN, RN

"We believe when all five of these pillars are practiced intentionally, you're building equity into your processes. In the second phase, we'll work with stakeholders to put together a strategy with a road map tailored to the unique needs of the organization and its audiences," Krzanowski said. That work could begin in the second quarter of 2023.

Continuous Improvement

ENA staffers focused on DEIJ efforts say the assessments, along with the rest of work toward DEIJ, boil down to continuous improvement.

"We're taking this on to challenge ourselves and the organization to continually improve and put out the best educational content, the best conferences and all that we do that ultimately is to optimize patient care through a DEIJ lens," said ENA Senior Manager of Research Altair Delao, MPH, a co-chair of the DEI staff council.

ENA member Hershaw Davis Jr., MSN, RN, a co-chair of the member DEI committee, said the assessments and other actions ENA has taken in recent years toward DEIJ represent a good start.

"I really believe ENA is leading the way with this initiative," said Davis, clinical faculty at University of Maryland School of Nursing.

"I am a firm believer in having inclusive spaces within our organization, and these surveys are helping to expand that work and really make us aware of how the organization is relating to its members and staff through diversity, equity, inclusion and justice. We're creating a road map for ourselves and something other organizations can follow in this work," Davis said. ●

You Could Be in the Next Class of 20 Under 40

ENA Connection has celebrated two 20 Under 40 classes showcasing exceptional up-and-coming nurses, and we're excited to do it again this year.

At the end of the month, applications and nominations will be accepted for the 2023 class of 20 Under 40.

The 20 Under 40 program casts the spotlight on emergency nursing professionals making extraordinary contributions to their workplaces, their communities and the emergency nursing specialty, while striving to showcase the diversity of the profession.

If you're an ENA member currently in the emergency care field and you started 2023 under the age of 40, throw your hat in the ring for this unique honor. Feel free to nominate a colleague or two who also deserve to be a part of the 2023 class of emergency nursing superstars.

Honorees will be highlighted at Emergency Nursing 2023, and profiles of the 2023 class will appear in the October issue of _ENA Connection_.

Application and nomination forms will be available March 27 to April 28 on the _ENA Connection_ homepage at www.ena.org/connection.

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A Broadening Study

By Matt Hanley
ENA CONNECTION CONTRIBUTOR

UAE Cultural Exchange Offers Members Perspective on Global Nursing

ENA reignited its pre-pandemic global cultural exchange in November, providing a unique opportunity for members to explore health care in the United Arab Emirates.

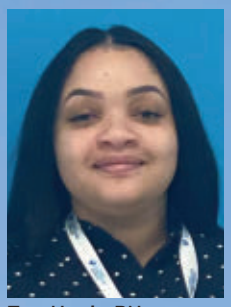
When ENA announced the in-depth culture exchange to the UAE, members jumped at the opportunity to learn about emergency nursing there while sharing their own experiences. Members who flew to the Emirates each had their own type of excitement.

Jarolito Ruiz, MA, RN, CEN, TCRN, assistant director for nursing professional development at Bellevue Hospital Center in New York,

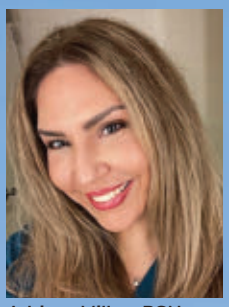
The UAE trip included visits to hospitals in the Emirates as well as local excursions

applied for the program because of his innate curiosity. Ruiz grew up in the Philippines — a country with a long tradition in nursing — and returns there often to train young nurses. That mentorship makes him want to learn everything he can about delivering care and handling workflow.

Jarolito Ruiz, MA, RN, CEN, TCRN



Tara Harris, RN



Adriana Millan, BSN, RN, PHN

Tara Harris, RN, an emergency department nurse at Mercy Fitzgerald Hospital in Pennsylvania, was intrigued. She wants to excel at her craft, but she had been a nurse less than two years; she couldn't imagine she'd be a good fit for the excursion. Late one night, she sent a tentative email asking whether it would be beneficial for a new nurse to go. She wondered: What were the requirements?

Adriana Millan, BSN, RN, PHN, a clinical nurse at Cedars-Sinai Medical Center in Los Angeles, was eager. Nursing is her second career, and she feels she has no time to waste. She wants to make her workplace safer now.

"I'm still in the beginning part of my career, but I want to contribute to making changes to policy and practices where I work and where I live," she said. "I don't want to wait until I've been an ED nurse for 20 years to have a point of view that would be beneficial."

Within months, the cultural ambassador, the rookie and the go-getter were all traveling together for an experience that would forever alter their perspectives. A total of 30 members and ENA staff flew to the UAE, staying seven days in November and touring health care and cultural sites.

"It was the best thing I could have ever done in my life, other than becoming a nurse," Harris said. "I'm going to carry this with me the rest of my career."

A Tradition Reborn, Reimagined

ENA conducted cultural exchanges in 2018 and 2019 but suspended them during the COVID-19 pandemic. The 2022 UAE trip restarted the program and refocused its intent. Past trips had been to European nations with long-established health care systems — but the UAE is only 51 years old.

When the UAE director of nursing invited ENA, the association jumped at the

opportunity to visit an emergency-care structure that's still developing, explained ENA Director of Member Engagement Matthew Hessler, CAE.

"We as an association want to be a global connection," Hessler said. "We're one of the few health care associations that doesn't have 'American' in the name. We're very proud of that, and we want to expand that. We want to support our specialty wherever it is practiced."

The one-week trip included visits to EDs and nursing schools in the cities of Abu Dhabi and Dubai. Ruiz, Harris and Millan had never been to the UAE. Millan has participated in medical missions in Guyana and Mexico, where the facilities had few resources. She discovered the opposite situation in UAE, as the wealthy country has a robust medical infrastructure. She and Ruiz were amazed by the in-depth simulation labs available in each hospital.

"I'm really envious of their training," Ruiz said. "I thought they would never be trained like us here. I have a lot of respect for them."

For nearly everyone, the big surprise was patient ratios, as Emirates nurses were responsible for just two or three patients at a time. Part of the reason for that dramatic difference is lower patient volume. In UAE emergency departments, there were almost no homeless patients, a small geriatric population and few patients with substance-abuse issues. Millan asked about violence in the ED; nurses said that while patients get frustrated, they don't attack staff.

"I got really emotional about that because where I work there's hostility and violence every shift," she said. And she knows those problems are not unique to the United States.

In fact, all three nurses commented on how different the EDs felt there. What might be called "customer service" in the United States is referred to as "customer happiness" in the UAE. That perspective shapes emergency services, too.

For instance, EDs display emergency severity index information on waiting room walls to help patients understand why some people are served first and to decrease patient frustration. While the American nurses acknowledged this would raise patient privacy issues in the states, they thought some aspects could be implemented in their EDs.

"I'm trying to figure out how to bring what I saw and start a conversation at home," Millan said.

What stood out to Ruiz were the monthly performance boards that include data on falls, medication errors and patient complaints for each shift. If the day is marked red, the team drills on that issue — identifying causes and developing prevention plans.

The UAE is a country most people hear about but most likely never visit — it has an almost mystical quality to it. Our delegation traveled there to collaborate with Emirates ED nurses and other health officials. We wanted to learn of their lives, training and how they practiced emergency nursing. We got so much more! We experienced culture alongside professional meetings. Our ENA group included professors, managers and clinicians, and we witnessed information sharing, open dialogue, a willingness to connect and make a difference. One thing stays true around the world: ED nurses everywhere go to work to make a difference in someone else's life.

— Vanessa Gorman, MSN, RN, CCRN, FAEN, FCENA, former ENA board member

During the one-week trip to the UAE, the ENA delegation, which included professors and clinicians, visited EDs and nursing schools and met with their health care counterparts

"I'm so impressed because they do it on a daily basis," Ruiz said. "[They] attack the problem and involve everyone. Right then and there, they solve it."

The Americans see an opportunity to help UAE nurses develop scope of practice. There's very little disaster and trauma training available in UAE hospitals, Ruiz said.

Also, because nurses are expats, the U.S. contingent also wants to help them continue to develop their homegrown nurses.

The ENA trip to the United Arab Emirates was more amazing than I expected. Our member delegates were engaged throughout the trip, and I was struck by how we all made immediate connections with nurses across the globe. Our hosts at each facility were gracious and hospitable. The whole experience reinforced for me that we're part of an amazing specialty of nurses who have a shared end goal: To educate ourselves to the best we can so we can care for our patients and help our communities. If you're thinking of taking a trip like this, I highly encourage you to spread your wings and experience something different.

— Ron Kraus, MSN, RN, EMT, CEN, ACNS-BC, TCRN, 2021 ENA president

Bringing It Home

For Millan, the second-career nurse from Los Angeles, the trip was satisfying.

"I felt so connected to everyone on this trip right away. I have 24 new friends," she said. "If you love being an ED nurse, there's no way you could go on a trip like this and come away empty-handed."

For Harris, the self-described "baby nurse," the trip was inspiring. She felt the other travelers valued her fresh perspective.

"It was so rewarding for somebody like me to see these experienced veteran nurses care so much about the future of emergency nursing," she said. "If you have doubts that you aren't qualified because you're a new nurse, push through those thoughts. Jump on these experiences."

Ruiz called the trip transformative. Although the primary focus was sharing information about nursing, organizers intentionally immersed the guests in local culture. They visited markets, palaces and houses of worship. They took a seminar on the country's laws and social norms — for example, in the UAE, ED patients are rarely interviewed alone, and a patient's family members are welcome to contribute care and give feedback.

These perspectives led the Americans to rethink patient interactions at home.

Multiple daily prayers are commonplace in the country where Islam is the official state religion. The Americans wondered: How are we accommodating this need for the patients visiting our EDs? And what concerns might be unique to a patient who wears a headscarf or a female patient who has no experience being treated by a male nurse?

Even after they returned, it was clear the impact has only just begun.

"It changed my perspective," Ruiz said. "You can't really learn about a place until you're in that particular place." ●

Evolving *with the* Specialty

By Jeff Zagoudis
ENA CONNECTION CONTRIBUTOR

Reimagined Membership Structure, Pricing Unveiled for 2023

Terry Foster, MSN, RN, CCRN, TCRN, CPEN, CEN, FAEN

Matthew Hessler

ENA recently announced a set of significant changes to its membership structure and pricing, scheduled to take effect this year. This marks the first major change to the membership structure since 2007 when ENA introduced the senior membership option for U.S.-based nurses 65 and older.

The COVID-19 pandemic exposed vulnerabilities in the global nursing workforce, leading to widespread staffing shortages and burnout among many nurses. In the 2021 Member Needs Assessment, ENA recognized a need to to make membership more affordable for early career nurses and recognize the long-term members.

"ENA has to be a continually evolving organization that can show existing members we are growing with them," said ENA Director of Member Engagement Matthew Hessler, CAE. "This sends the message to new members that we will grow with them as they continue their professional journey in nursing with ENA."

Maximizing Membership Value

The changes are meant to encourage those emergency nurses just starting in the field to participate in the association and engage with their peers as much as possible.

ENA recognizes that those just starting their journey in the field may need more assistance getting involved and engaged, according to Hessler. Many early career nurses are starting out in the emergency department, but turnover continues to increase year over year. Where emergency nurses (and others) used to stay in the profession for decades, many of today's ED nurses are leaving in three to five years, Hessler said.

With an eye toward making membership more accessible for these newcomers, ENA has introduced a graduated dues model, similar to other professional associations, for nurses in the first three years after their primary nursing education program. Membership for the first year for new graduates will be $50, increasing to $75 in the second year after graduation and $100 in the third year.

ENA President Terry Foster, MSN, RN, CCRN, TCRN, CPEN, CEN, FAEN, said he's met many student nurses over the years and is always impressed by their outsized enthusiasm. That needs to be harnessed, Foster said.

"Those nursing students are extremely engaged. They've done their fact-checking, they've done their research, and they're really excited about emergency nursing," Foster said. "This is when we need to capture this energy and this enthusiasm they have because we need that today."

ENA is also increasing membership pricing for National, International and Military members for the first time since 2015. National and International members will now pay $125 for a one-year membership, an increase of $10. Annual dues for military members will rise to $112.50, an increase of $8. Prices for three- and five-year membership options will also increase proportionally to the one-year option but still provide savings on multiple years of membership.

"This is not a decision the ENA Board of Directors took lightly. However, we have continued to proactively invest in new and enhanced member experiences, benefits and educational resources, and provide even more value, especially over the last several years," Hessler said.

> "All our members have expectations of us to meet their needs now and in the future. Our charge is to meet those expectations while also finding ways to deliver unexpected additional value."
>
> **— Matthew Hessler**

Hessler highlighted the ENA Advantage program as one way the association strives to bring additional value. ENA Advantage provides discounts and deals to association members from name-brand retailers and partners. This includes everything from discounts on scrubs and personal protective equipment, to Chamberlain University tuition discounts, to enhanced services when acquiring student or home loans. Last month, flight, hotel and rental car savings were added with an online search and booking tool. ENA Advantage means members also receive discount pricing on the latest education and events, including ENA's annual conference.

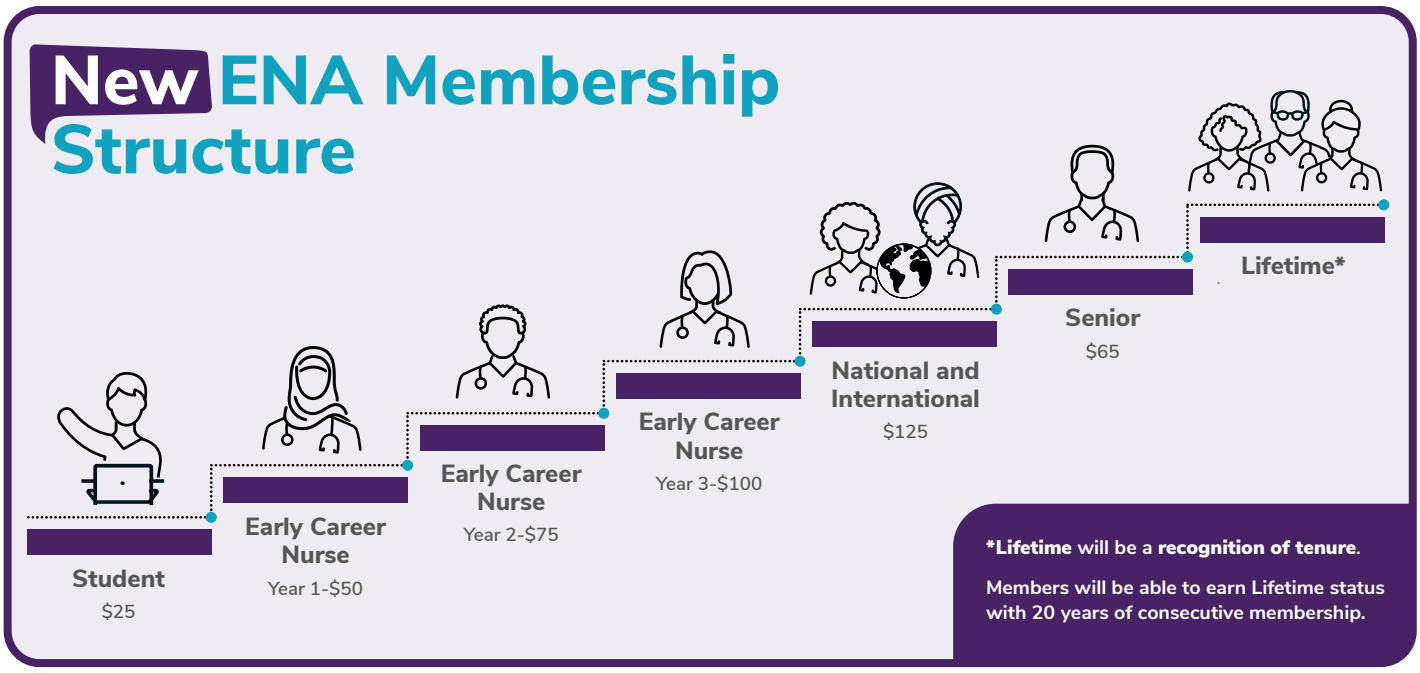
Hessler expects the changes to take place in the third quarter of this year. He noted that any payments made prior to the change to the new structure to extend membership for another year would be made at the current rates. Members up for renewal in 2023 will receive additional communication within 60 days before their expiration date.

"The changes we've implemented over the past several years and are implementing now are rooted in what we've heard loud and clear from our members in surveys, focus groups, in suggestions and questions raised to staff, and from our leaders, including the ENA board and General Assembly," Hessler said.

"All our members have expectations of us to meet their needs now and in the future. Our charge is to meet those expectations while also finding ways to deliver unexpected additional value."

In January, ENA announced it will sunset the current paid Lifetime membership. All ENA members with 20 or more consecutive years of membership will receive Lifetime status, establishing a career milestone that rewards the association's most dedicated supporters, Hessler said.

"It's important to recognize the commitment and investment of our members in meaningful ways," he added. ●

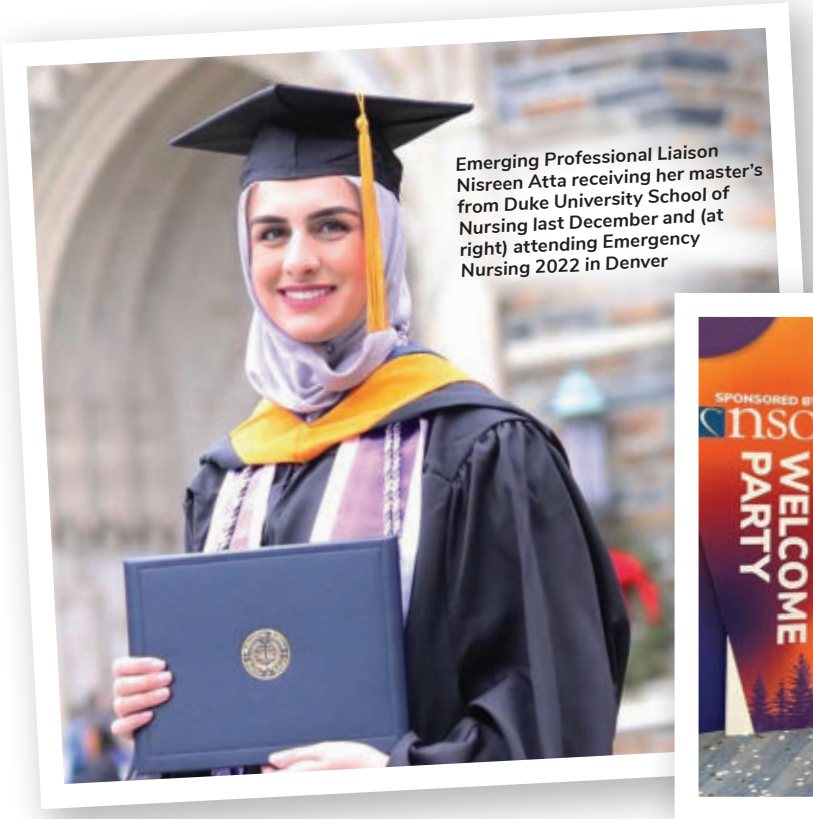


ENA's new membership and pricing structure is scheduled to go into effect in the third quarter of 2023

By Elizabeth Stanton
ENA CONNECTION CONTRIBUTOR

Difference Maker

Advocate, Nursing Leader Nisreen Atta Is 2023 EPL



Emerging Professional Liaison Nisreen Atta receiving her master's from Duke University School of Nursing last December and (at right) attending Emergency Nursing 2022 in Denver

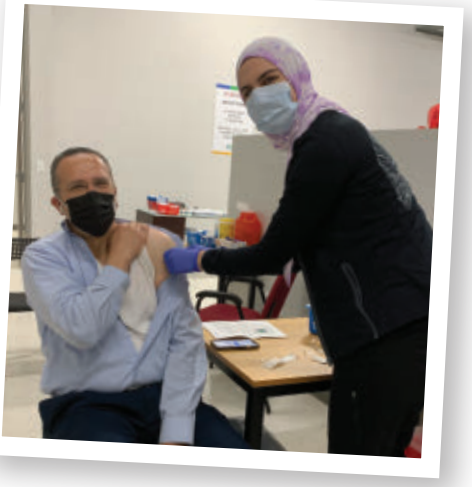
Nisreen Atta, MSN-Ed, RN, describes herself in many ways. Daughter. Sister. Lifelong learner. Mentor. Mentee. Wisconsinite. Palestinian American. Muslim. Educator. Emergency nurse. ENA lifetime member.

Each element helps define who Atta is. And when you talk to her, you soon learn that this list is just the start.

In December, 25-year-old Atta added a master's degree and a new title to the growing slate: ENA's emerging professional liaison — a role that leverages Atta's leadership and advocacy experience and skills.

The week before graduating from Duke University School of Nursing with her master's in nursing education, she received a call from then-ENA President-Elect Terry Foster, MSN, RN, CEN, CPEN, CCRN, TCRN, FAEN, who told her she was named the 2023 Emerging Professional Liaison on the ENA Board of Directors.

Atta was at work in the emergency department at Aurora St. Luke's Medical Center in Milwaukee when she received the news. She was stunned. As the EPL, Atta is a nonvoting member of the board who provides the perspective of a nurse with less than five years of



Atta proudly administered the COVID-19 vaccine to her father at a local pharmacy

experience. This rotating position started in 2018 and creates a space for new nurses to share their voices.

Atta said she'd like to use the role to identify ways ENA could improve the work environment for current emergency nurses and those who will serve in the specialty in the future.

"I would love to bring in more emerging professionals to ENA," Atta said. "Not just as members, but to encourage more involvement in committees and volunteering because this is honestly a very difficult time in emergency nursing."

Leadership Potential

Wisconsin born, bred and based, Atta has worked in her Milwaukee ED since 2016, when she started there as an ED tech at age 19. In January 2020, just before COVID-19 swept across the country, she started a full-time nursing job there and discovered herself in a new ED reality.

Jennifer Hafemann, MS, BSN, RN, NE-BC

Jennifer Hafemann, MS, BSN, RN, NE-BC, director of emergency services and nursing operations at Aurora St. Luke's, said Atta helped set the pace of the response as the ED tried to navigate the crisis.

"She was researching outside of work, reading journals, responding to emails, texting ideas," Hafemann recalled. "She wanted to make the flow process within the ED work for the patients and work for the ED team. That's just the type of person she is. She wants to be involved with everything because she wants to truly make a difference." Hafemann said she expects Atta to step into her EPL role in the same way.

The two nurses met when Hafemann started a new ED leadership position and Atta was still an ED tech. Atta often stepped up to help Hafemann.

"I was a total fish out of water, since my experience was inpatient based," Hafemann recalled. "Nisreen was there to help, and she was one of my main go-to people. She wanted to help me get to a comfort zone there."

Since then, Hafemann has watched Atta, who she calls "a transformational leader" and "nursing advocate" grow as a nurse and person.

"Being a newer nurse, the way she advocates — she has a political savviness to her already so early in her career that I see her going places," Hafemann said. "She has the passion, and she has the heart."

Advocacy in Action

Atta is no stranger to advocating for the needs of her colleagues and patients in and out of the ED. She served as shared governance chair at her hospital, where, during the pandemic, she advocated for higher pay for staff nurses to match that of travel nurses.

"She put herself out there to advocate for the team because she felt that she needed to be their voice," Hafemann said.

Atta also has been the Milwaukee regional director of the Wisconsin ENA State Council since January 2021, advocating for state members.

"So many people along my journey were positive influences, and I want to be that person for others," she said.

Atta's drive to help others comes in large part from her family. The Attas were one of the first Muslim families in Wisconsin, with roots in the state that reach back to 1914. Atta grew up in what she describes as a "large, beautiful Palestinian family" and raised with a focus on education, community service and giving back.

"While growing up, I was continuously encouraged to prioritize learning, help others and strive to do better — all of which are values that connect to nursing and the passion I have for nursing," she said.

Atta encourages others to do their best and not doubt themselves.

"Oftentimes with diverse individuals, we say no one's ever done this before, or I don't see people who look like me doing this, and I want to be that person to help inspire others," she said.

Atta's goal on a local ENA level mirrors what she'd like to achieve nationally. She said every part of her journey with ENA — from a student nurse to her role on the ENA Board of Directors — has been built on what she's learned from the association.

"I want to see ENA in every single ED," she said. She knows encouraging someone to join a new organization can elicit skepticism, but she is ready to respond.

"Oftentimes the question is, 'What can you do for me?'" she said. "And my answer is, 'Well, let me tell you!'" ●

ENA Board of Directors December Meeting Highlights

By Ashley Schuring
ENA CONNECTION CONTRIBUTOR

In December, the ENA Board of Directors met in Schaumburg, Illinois, for its last quarterly meeting of 2022. Key action items discussed include:

2023 Budget and Organizational Goals: The board approved ENA's 2023 budget and organizational goals, which are focused on achieving the priorities of the 2020-2025 Strategic Plan. ENA plans to build on its ongoing growth and impact, including five priority areas: improving the emergency nurse's practice environment; expanding the voice of ENA and the emergency nurse; increasing the number of students taking ENA programs and courses; growing the ENA member community; and creating positive and engaging ENA experiences.

The board also reviewed the final performance to date on 2022 organizational goals and key accomplishments, such as the launch of the ED Nurse Leadership Pathway, Emergency Nurse Residency Program and ENA Triage Curriculum. The ENA Foundation marked increased donor engagement with three new grant opportunities last year and goal-shattering donations at Emergency Nursing 2022.

ENA Orientation: The ENA Board of Directors participated in board orientation to review key governance principles. Members participated in activities to continue to grow the support and engagement with members and chapters and conducted an exercise to reflect on the board culture statement, which reads, "We, the ENA Board of Directors, will seek at all times to demonstrate excellence through collaboration, engagement, and accountability; integrity through respect, compassion, and mindfulness; a culture of inquiry while being inclusive, strategic, and visionary."

The board and the ENA Foundation Board of Trustees also participated in a shared orientation process, setting the tone for strong collaboration between the boards and solidifying their best practices in governance and leadership.

Practice Resources: At nearly every meeting, the ENA Board of Directors approves a variety of new or revised position statements, valuable tools created through the dedicated contributions of our member volunteers that continue to support ENA's mission. At this meeting, the board approved a revised position statement, Substance Use Disorders and Addiction in the Emergency Care Setting.

Healthy Work Environment: The board continues to advance ENA's Healthy Work Environment Roadmap. This initiative focuses on educating, supporting and advocating for healthy and safe work environments for emergency nurses. Based on pilot work occurring in 2022, the board approved a new suite of services that will continue to advance this important work. The board expects to announce more details in 2023.

Education Portfolio Update: The board received an update on the development of ENA's educational portfolio. This work focuses on ensuring timely new and revised educational offerings and providing the highest quality educational resources for emergency nurses. Several new and revised programs launched in the last quarter of 2022, including ENPC, 6th Edition; CEN Review Manual, 6th Edition, and the revised CEN Online Review; and the ENA Triage Curriculum.

ENA will expand its offerings with several resources under development. These include TNCC, 9th Edition, with several translations; a reimagined CATN offering; a refresh of the Industry Learning Lab program; and a Nursing Professional Development Pathway for Educators.

AEN Trailblazer Program: The Academy of Emergency Nursing's Trailblazer Program creates an opportunity for Fellows to explore and discuss the key issues in emergency nursing and provide leadership for the Academy Board and the ENA Board of Directors.

The Trailblazers created two groups, each addressing its own question and, ultimately, creating a related white paper. The first group addressed the question: "Under an assumption the staffing crisis is sustained, how should emergency care be delivered given a shortage of emergency nurses?" The question for the second group — "What solutions should be employed to recruit and retain emergency nurses practicing in the specialty?" — led to a white paper that the board approved in December. Both white papers can be found on the Academy webpage, **www.ena.org/faen**.

Below: Attendees at Emergency Nursing 2022 filled in weathergrams to honor those people lost during the pandemic

Above: On the winter solstice, the ENA staff and Board of Directors hung the weathergrams on trees and bushes behind ENA Headquarters

Membership Structure: ENA continues efforts to increase membership and strengthen its value proposition to ensure it can continue to recruit, engage and retain more emergency nurses.

In September, the board discussed key components of the updated membership structure, including a graduated dues structure for ENA's newest members and additional value for lifetime members. Staff continued to refine the updated membership structure with feedback from key stakeholders. At the December meeting, the board reviewed the launch plan for the new member structure, which includes membership evolution and ENA's journey toward being more globally inclusive and better support of new graduates and longtime members.

Leadership Development and Selection Work Group Update: Over the past two years, the ENA Board of Directors and the Nominations and Elections Committee have each implemented new leadership development and selection processes to strengthen ENA's leadership pipeline. This includes the creation of the board self-assessment process and enhancements to the elections process that started in the 2022 election cycle.

Over the summer, the board approved creating a Leadership Development and Selection Work Group, composed of board and NEC members, which will continue to evolve best practices in choosing and developing leaders. This group will assess impacts of the recent process improvements and recommend future process improvements and program development.

At the December meeting, an update on the work group's progress was shared. Its recommendations will be shared with key stakeholders for evaluation, finalization and implementation in the year ahead.

Journal of Emergency Nursing: Interim Editor-in-Chief Gordon Gillespie, PhD, DNP, RN, CEN, CNE, CPEN, PHCNS-BC, FAEN, FAAN, provided his final update to the board. The journal now incorporates more clinical content, a move that aligns with *JEN*'s strategic direction and with feedback received from a 2022 readership survey. The board recognized Gillespie's six months of leadership and welcomed Anna Valdez, PhD, RN, PHN, CEN, CFRN, CNE, FAEN, FAADN, who started as the new editor-in-chief in January. ●

ENA Practice Resources Spotlight

ENA regularly develops a variety of practice resources through its volunteer groups and subject matter experts in collaboration with ENA staff. These resources are offered free to members and include position statements, topic briefs, clinical practice guidelines, toolkits, infographics, executive summaries, technical reports and white papers.

ENA Connection highlights several of these practice pearls of wisdom.

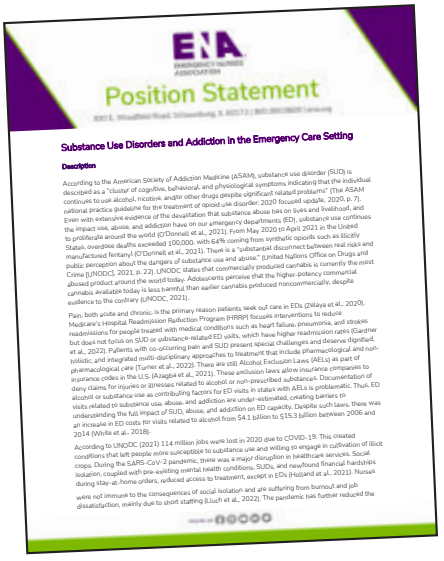
The practice resources include relevant clinical information to help emergency nurses improve care and overall safety for specific patient populations and situations in the emergency department.

ENA's practice resource library is exclusively available through ENA University at **www.ena.org/enau/practice-resource-library**.

Substance Use Disorders and Addiction in the Emergency Care Setting

Patients battling a substance use disorder may come to the ED with a variety of related or unrelated issues. In this revised position statement, approved by the ENA Board of Directors in December, ENA outlines the need for emergency care providers to offer dignified, respectful and compassionate care to patients presenting with pain, regardless of whether the patient has a substance use disorder.

EDs must provide crisis intervention and stabilizing treatments for patients with substance use disorders, taking into consideration the physical and psychological consequences of an SUD. Health care facilities need to educate employees on their established policies and procedures.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Position Statement

Substance Use Disorders and Addiction in the Emergency Care Setting

Description

According to the American Society of Addiction Medicine (ASAM), substance use disorder (SUD) is described as a "cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems" (The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update, 2020, p. 7). Even with extensive evidence of the devastation that substance abuse has on lives and livelihood, and the impact use, abuse, and addiction have on our emergency departments (ED), substance use continues to proliferate around the world (O'Donnell et al., 2021). From May 2020 to April 2021 in the United States, overdose deaths exceeded 100,000, with 64% coming from synthetic opioids such as illicitly manufactured fentanyl (O'Donnell et al., 2021). There is a "substantial disconnect between real risks and public perception about the dangers of substance use and abuse." (United Nations Office on Drugs and Crime [UNODC], 2021, p. 22). UNODC states that commercially produced cannabis is currently the most abused product around the world today. Adolescents perceive that the higher potency commercial cannabis available today is less harmful than earlier cannabis produced noncommercially, despite evidence to the contrary (UNODC, 2021).

Pain, both acute and chronic, is the primary reason patients seek out care in EDs (Zelaya et al., 2020). Medicare's Hospital Readmission Reduction Program (HRRP) focuses interventions to reduce readmissions for people treated with medical conditions such as heart failure, pneumonia, and stroke but does not focus on SUD or substance-related ED visits, which have higher readmission rates (Gardner et al., 2022). Patients with co-occurring pain and SUD present special challenges and deserve dignified, holistic, and integrated multi-disciplinary approaches to treatment that include pharmacological and non-pharmacological care (Turner et al., 2022). There are still Alcohol Exclusion Laws (AELs) as part of insurance codes in the U.S. (Azagba et al., 2021). These exclusion laws allow insurance companies to deny claims for injuries or illnesses related to alcohol or non-prescribed substances. Documentation of alcohol or substance use as contributing factors for ED visits in states with AELs is problematic. Thus, ED visits related to substance use, abuse, and addiction are under-estimated, creating barriers to understanding the full impact of SUD, abuse, and addiction on ED capacity. Despite such laws, there was an increase in ED costs for visits related to alcohol from $4.1 billion to $15.3 billion between 2006 and 2014 (White et al., 2018).

According to UNODC (2021) 114 million jobs were lost in 2020 due to COVID-19. This created conditions that left people more susceptible to substance use and willing to engage in cultivation of illicit crops. During the SARS-CoV-2 pandemic, there was a major disruption in healthcare services. Social isolation, coupled with pre-existing mental health conditions, SUDs, and newfound financial hardships during stay-at-home orders, reduced access to treatment, except in EDs (Holland et al., 2021). Nurses were not immune to the consequences of social isolation and are suffering from burnout and job dissatisfaction, mainly due to short staffing (Liuch et al., 2022). The pandemic has further reduced the

The position statement notes that nurses are just as likely as the public to abuse substances as a coping mechanism and examines an appropriate approach to the problem. Emergency nurses must realize drug diversion for personal use is mainly "a symptom of a serious and treatable disease and not exclusively a crime," the position statement said. Hospitals and nursing schools are encouraged to develop alternative-to-discipline programs.

This update incorporates research about how the COVID-19 pandemic placed unique stressors on health care workers, putting them at higher risk for alcohol and substance use disorders.

Use of Thromboelastography (TEG) in the Emergency Department

Thromboelastography, a whole-blood point-of-care lab test gauging the blood's ability to clot, can be used in the emergency setting to address coagulopathy and guide transfusion treatment for patients. This topic brief explores the value of TEG as a rapid, additional tool to analyze bleeding and coagulopathy among trauma patients.

TEG has the potential to assess the cause of and control bleeding in trauma patients, and TEG results can help guide the trauma team as it determines an appropriate treatment.

The topic brief surveys current research on TEG's potential to improve survival rates and reduce the use of blood products. It also outlines the role emergency nurses might play in interpreting results of TEG analysis, formulating appropriate therapeutic goals and the feasibility of incorporating TEG in trauma resuscitation. Emergency nurses are also well positioned to contribute to research on using TEG to better manage patients with massive hemorrhage. ●

We can HELP YOU...

With more than $600,000 in scholarship and grant funding available for 2023, ENA Foundation is a dedicated resource for nurses seeking to advance their career.

The ENA Foundation **powers the future of emergency nursing** with a mission focused on providing emergency nurses with **academic scholarships**, **research grants** and **continuing education opportunities** including attending **Emergency Nursing 2023 in San Diego, Sept. 21-23**.

...Make an IMPACT

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- **EMF/ENAF Health Safety Measures for ED Professionals Research Grant (Up to $50,000):** October 20-January 20
- **Emergency Nursing Diverse Voices Research Fellowship (ENDVR):** January 9-February 17
- **Conference Scholarships (International applicants):** January 16-February 20
- **Academic Scholarships:** March 1-April 29
- **Conference Scholarships (U.S. applicants):** March 14-April 18
- **Research and Implementation Grants (Grants starting at $500 and up $6,000):** July 10-August 28

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For more information on eligibility and submission procedures, visit ena.org/foundation or call 847.460.4100.

Looking Forward

Two Foundation Scholarships Support Emerging Leaders

By Juan Pablo Garcia, MSN, RN, CNL
ENA CONNECTION CONTRIBUTOR

Krystal Walters and Javon Turner received ENA Foundation scholarships to help their careers in emergency nursing

The work to become an emergency nurse is often difficult and takes significant effort. For Krystal Walters, BSN, RN, and student Javon Turner, receiving an ENA Foundation scholarship came as a financial relief and represented a special recognition for their commitment and contribution to the emergency department.

Walters, who graduated last year with a bachelor's from Rasmussen University in Fort Myers, Florida, received the 2022 ENA Foundation Endowed Undergraduate Scholarship, and Turner, who is working toward an associate's degree in nursing at Community College of Baltimore County, received the ENA Foundation Non-RN Scholarship for Emergency Department Workers.

While Walters and Turner have different stories, they both said they hadn't planned on working in an ED. The ED found them.

The Road to the ED

Walters' first job as a licensed practical nurse was in pediatrics with a home health company. She had always wanted to work with kids, but because her goal was to get her nursing license, she sought to build a better-rounded clinical experience. She applied to Gulf Coast Medical Center, which was hiring workers with LPN accreditation.

Turner was driving taxi cabs and one night picked up a doctor and three nurses. He took the fare as a sign, as he had been thinking about a career change, so he enrolled in a CNA course. Soon, Turner heard about Johns Hopkins Hospital's Soaring program, an internship that prepares nursing assistants to practice in an advanced patient care role. That eventually led him to the ED.

Neither Walters nor Turner had initially set their eyes on the ED, but both fell in love with emergency care.

"The thing that I love the most about working in the ED is being able to use critical thinking and constantly seeing people with different types of situations and getting to use those critical skills to truly make a difference for people," Walters explained. "No two days are alike."

"I like the variety of what you see, the variety of people, some going upstairs to be admitted, others discharged for after-care," Turner said. "I work in a Level I trauma center, so you never know what's going to come through the back door. When you hear the call, you know what your job is and what you have to do, and you go back there, and you do it and you pray you can save a life."

A Passion for Teaching

Both Walters and Turner excel at their jobs, going out of their way to help others and have an interest in clinical education. Walters, for example, took the time during her clinicals to engage with her peers and share her knowledge.

> “When someone gets a scholarship from the Foundation, they often feel a kind of obligation to pay it back and pay it forward. In my personal experience as an award recipient, I felt that obligation, and that’s what drives me to be involved with ENA.”
>
> **— ENA Foundation Chair Mike Hastings, MSN, RN, CEN**

“My clinical experience helped me help my classmates. I was the momma duckling; I used my experience to help them out with things they hadn’t seen or to understand disease processes or when they struggled emotionally with situations,” Walters said.

Turner also has an interest in teaching.

“I definitely want to do some education. I want to go into teaching eventually,” Turner explained. “I teach a new-hire class together with another tech, and that gave me a passion for instructing.”

The Big Picture

Both Walters and Turner said in the time they’ve spent in the ED, they’ve found more than a job — they have identified a profession where they want to connect with nursing peers across the country. In other words, their commitment to emergency nursing has them thinking beyond stretcherside care to consider some of the big issues facing nursing.

Walters is an active member of the National Student Nurses Association; she is the vice president of the local chapter. She tutors, coaches and supports students at Rasmussen University and volunteers at pinning ceremonies. In addition, as an ENA member, Walters attends local chapter meetings and events, such as the EN Week 5K.

Turner is an active member of the American Association for Men in Nursing, ENA and NSNA, and he’s the secretary of the Maryland Association of Nursing Students and co-chair of the Catonsville Student Nurses Association.

As they balance school and work and find time to give back to the profession they pursue, Walters and Turner are busy people. The financial support from their scholarships provides a well-deserved break.

Above: Turner enjoys a festive moment with colleagues

Right: Walters with Ely Gonzalez, a friend Walters helped mentor in emergency nursing

"This scholarship gives me some room to breathe," Turner explained. "This will help finances in my future. I don't have to work overtime to make sure I have books for nursing school."

Walters echoed that idea, recalling how the scholarship helped her breathe during the last year of her bachelor's program, a time when she was hyperstressed over finances.

But more than the money, their scholarships are recognition that they are on the right track and that their efforts are not in vain, they agreed.

"That the scholarship comes from ENA itself means so much," Walters said. "Emergency nursing is a tight-knit community, and this award made me feel like I belonged."

"It motivates me to keep doing what I'm doing and makes me hopeful about my future," Turner said. "It's an incredible recognition coming from such an important organization."

For ENA Foundation Chair Mike Hastings, MSN, RN, CEN, Walters and Turner not only embody the Foundation's values but also demonstrate the purpose of the Foundation's scholarships.

"When someone gets a scholarship from the Foundation, they often feel a kind of obligation to pay it back and pay it forward." Hastings explained. "In my personal experience as an award recipient, I felt that obligation, and that's what drives me to be involved with ENA."

The Foundation scholarships can encourage those who are committed to the profession and promote the next generation of leaders in the specialty.

"Krystal and Javon highlight the future of nursing and how the ENA Foundation helps support future nurses for our specialty," Hastings said. ●

LIGHTING THE WAY:

N.Y. ED Improves Throughput by Shift in Mindset, Responsibility

By Alexandra Pecci
ENA CONNECTION CONTRIBUTOR

Staff at the Lantern Award-recognized Huntington Hospital ED in Huntington, New York

A simple change in mentality led to a major process change and national recognition for the Lantern Award-recognized Huntington Hospital emergency department in Huntington, New York. Much of the change comes down to the difference between a push and a pull.

When an ED patient needs to be admitted, they're typically described as being "sent" or "pushed" to a floor.

The department added a "pull process," a throughput project to decrease the decision to admit-to-floor times, explained one of the architects of the program, ED Director of Patient Care Services Michael Recupero, MSN, RN, NE-BC. It required a collaborative effort among many disciplines, he said.

Formerly, ED nurses were responsible for "pushing" patients to an inpatient floor. But when the accepting nurses on that floor were unavailable, the process was delayed and patient waits increased.

That's why the process change also included a mindset change. The pull process shifted the responsibility away from ED nurses and on to nurses in the accepting unit. The inpatient nurses would "pull" patients from the ED by initiating the nurse handoff communication. The multistep process included defined roles and tasks for everyone involved and steps to take if those tasks were delayed.

The new process improved the time between a bed being assigned and being occupied. Before the change, the assigned-to-occupied rate hovered around 87 minutes. After, it dropped to 49 minutes and dropped again to 46 minutes the following year.

Separately, Recupero is also proud of the department's efforts to keep its nurses healthy and supported, both at work and at home.

"This initiative not only looks to decrease stress while on the job but promotes healthy living regardless of where you are," he said.

At work, nurses access on-site stress-reduction programs, such as guided meditation, progressive muscle relaxation, reiki and chair yoga. An on-site relaxation room offers a massage chair, aromatherapy and meditation music. The ED also uses an exercise challenge app and hosts virtual and in-person wellness retreats.

Valued nurses translate to exceptional patient care.

"We are a community hospital with over 100 years of service to the community," Recupero said. "Patient experience is at the forefront of everything we do. Each patient and their families are treated as one of our family." ●

Four Times a Charm

Illinois ED, Four-Time Lantern Award Recipient, Innovates for Patients

By Alexandra Pecci
ENA CONNECTION CONTRIBUTOR

Members of the ED team at Advocate Good Shepherd Hospital in Barrington, Illinois

Receiving the Lantern Award multiple times is an amazing accomplishment, but the emergency department at Advocate Good Shepherd Hospital in Barrington, Illinois, has raised the bar even more as it receives its fourth Lantern Award recognition.

"We're very focused on the needs of the patients," said Dawn Moeller, MHA, BSN, RN, CEN, clinical manager for emergency and trauma services at Advocate Good Shepherd Hospital.

The ED has a strong team and its leaders receive support from the organization to keep their nurses engaged and help them feel valued. Those leaders maintain an open-door policy that emphasizes listening and teamwork, Moeller said.

That ethos and example start at the top of the department. Moeller and Karla Christianson, DNP, MSN, CEN, the ED clinical nurse specialist, have worked together for 17 years and provide a solid leadership team, keeping each other and the department grounded.

"I think having a consistent team of leaders has helped," Moeller said. "We always call each other 'peas and carrots.'"

Christianson agreed, saying they huddle together, run ideas by each other and make sure to include the other in all decisions.

"We have the same passion and the same vision," Christianson said. "It role-models the collegial working relationship."

Echoes of that collegial relationship are evident in the department's nurse-led initiatives and dedication to patient care. For example, the ED has worked to reduce recidivism among patients with high ED usage. In a major departure from the episodic care EDs usually provide, the program creates interdisciplinary and individualized care plans for patients. The program focuses on "the why" of patient visits and features collaboration between the patient and multidisciplinary care plan team.

"It was driven from the front lines," Moeller said.

The program's success speaks for itself: The department received a $25,000 grant for the program from its state hospital association, and CMS highlighted it as a best practice in 2019.

In addition, over the past decade, they've averaged a 51 percent reduction in ED recidivism and a 46 percent reduction in unnecessary admissions. They've also saved $9.4 million for ED revisits and $3.7 million for unnecessary admissions.

It highlights the way everyone in the ED works together, valuing each other's input and expertise.

"Karla and I are smart, but we're just a couple of brains," Moeller said. "We've got a hundred of them out there!" ●

ENA's Lantern Award® recognizes EDs that exemplify exceptional and innovative performance in leadership, practice, education, advocacy and research. EDs receiving the Lantern Award demonstrate a commitment to quality, safety, a healthy work environment, and innovation in nursing practice and emergency care.

ENA Connection is featuring each 2022 Lantern Award recipient in an issue of the magazine.

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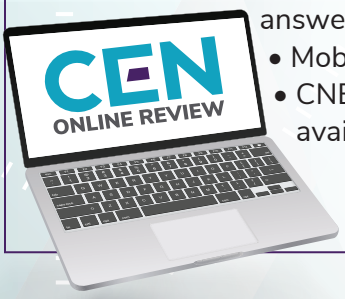

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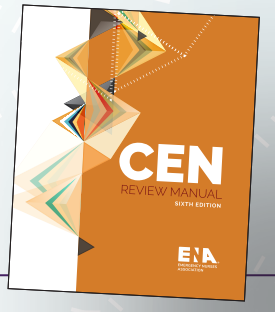

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