Advocating for Safety in the Workplace

Dear Editor:

The clinical article by Andrew Harding published in the May 2011 issue of Journal of Emergency Nursing entitled “Education and Culture: Mitigation for Workplace Violence” points out that “a culture of safety is the antecedent to the education and skill training that can be implemented to mitigate the risks of violence in our emergency departments.” This statement speaks to the fact that ED nurses need to take a stand to advocate for the remaining 12 states that have not yet adopted legislation that provides increased penalties for assault of health care workers.

Kudos to Massachusetts Governor Deval Patrick for recognizing that ED nurses are standing in harm’s way on a daily basis to care for others. In fact, 8% to 13% of nurses in the emergency department are victims of violence weekly. Sadly, my own state of Texas is among those that have not passed this much-needed legislation. I encourage all readers to write to your representatives to motivate them to pass legislation to protect our nurses. I encourage those who live in states that already benefit from this legislation to write to other state representatives to describe the impact it has had on your environment. Together we can take a stand against workplace violence on nurses.—Melissa Alvarado, BSN, RN, CEN, Member, Tarrant County ENA, Graduate Student, University of Texas–Arlington College of Nursing, and Clinical Educator, Emergency Department, Denton Regional Medical Center, Denton, TX; E-mail: Melissa.Alvarado@mavs.uta.edu

doi: 10.1016/j.jen.2011.08.013

REFERENCES

Interactions Among Benzodiazepine and Buprenorphine/Naloxone

Dear Editor:

We read with interest the recent article by Heather Martin entitled “The Possible Consequences of Combining Lorazepam and Buprenorphine/Naloxone: A Case Review.” It is an interesting case study and we would like to express our thoughts on the drug interactions among benzodiazepine and buprenorphine/naloxone based on the literature review.

In this case study, the author claimed that administering a benzodiazepine depressant to patients taking buprenorphine/naloxone can be life-threatening, and suggested that benzodiazepines should be avoided when treating anxiety in patients taking buprenorphine/naloxone. Benzodiazepine is widely used in the world for anxiety and insomnia. Its use and abuse is even more widespread in populations of illegal drug abusers. The synergistic toxic effects of benzodiazepine with buprenorphine/naloxone might depend on the types of benzodiazepines. Lorazepam seldom causes death by itself but interacts with buprenorphine, methadone, and other opiates or cocaine with sometimes fatal results. The author discussed the interaction between benzodiazepine and buprenorphine but did not mention the interaction between benzodiazepine and naloxone. However, most recent clinical research shows that naloxone might directly interact with benzodiazepine and have benefit effect in benzodiazepine intoxication, which is very interesting and important to know for the clinical use of these drugs.

Naloxone is well known for the treatment of addiction to opiates, as well as ethanol and some other drug intoxication. Animal studies show that naloxone directly antagonizes the GABA/benzodiazepine receptor function in the rat. Electrophysiological data show that GABA-induced inhibition of neuronal firing in the rat brain can be antagonized by naloxone. Furthermore, in experimental animals, naloxone antagonizes benzodiazepine-induced various behaviors, such as hyperdipsia, hyperphagia, anticonflict effects, and anxiolytic-like effects. Recent clinical research shows that naloxone improves clinical symptoms and signs of benzodiazepine poisoning, including lethargy, weakness, ataxia, dysarthria, and decreased consciousness level, in patients without a history of illegal drug use. These animal and clinical
research studies provided direct evidence for the interaction between benzodiazepine and naloxone.

This case study and literature review by Heather Martin provided useful information for the clinical use of benzodiazepine and buprenorphine/naloxone. However, the exact interactions and mechanisms among benzodiazepine, buprenorphine, and naloxone need further clinical and animal studies.— Weiqing Yuan, MD, PhD and Barry N. Williams, MD, Department of Psychiatry, Forsyth Medical Center, Winston-Salem, NC; E-mail: weiqingyuan@yahoo.com

doi: 10.1016/j.jen.2011.08.010

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Priority Preparedness Issues

Dear Editor:

September 2011 is a month to recognize and reflect upon the 10-year anniversaries of the September 11, 2001, and East Coast anthrax attacks and the 6-year anniversary of Hurricane Katrina. These tragedies remind us of the harsh reality of foreign and domestic terrorism within the United States and the destructive capability of natural hazards such as hurricanes. The scarce medical resources available for victims of Hurricane Katrina made the Agency for Healthcare Research and Quality’s 2005 “Crisis Standards of Care” concepts a reality as several New Orleans area hospitals sought to provide the best care possible in the worst circumstances. The anniversaries of these catastrophes provide benchmarks for gauging our past preparedness level, current status, and opportunities for the future.

Since September 11, 2001, national progress has been made in disaster and preparedness planning in a number of areas with regard to emergency departments, hospitals, and health systems. Initiatives, programs, and funding include the Hospital Preparedness Program, the Pandemic and All-Hazards Preparedness Act, development of a National Incident Management System, and the National Response Framework. Progress has been reflected in preparedness policy change reflected in regulatory directives and standards such as those from the Centers for Medicare and Medicaid Services and The Joint Commission.

Yet significant preparedness and response challenges remain. In the 2007 Center for Biosecurity report “What Hospitals Should Do to Prepare for a Pandemic,” the average 164-bed hospital in the United States would require $1 million to be minimally prepared for the H5N1 pandemic as previously modeled by the Centers for Disease Control and Prevention. A large-scale natural disaster, infrastructure failure, or terrorist attack on a U.S. city with an improvised nuclear device or other nuclear explosive will result in significant casualties and medical resource needs that will shift from a contingency to a crisis level. In a May 2008 U.S. House of Representatives report, “Hospital Emergency Surge Capacity: Not Ready for the Predictable Surprise,” level I trauma centers in 7 major U.S. cities were surveyed for real-time emergency capacity. The surveyed centers were found not to have room in the emergency department for a sudden influx of casualties; virtually no free ICU beds; and a shortage of regular inpatient beds to handle the less severely injured. Capacity shortages were particularly acute in Los Angeles and Washington, DC.

What preparedness resources or capacities are needed, and which are priority issues? In June 2011, 2 questions were posted on the ENA emergency preparedness and manager’s listserv. Anonymous survey respondents were asked to select their perceived top 5 preparedness issues for (1) their hospital (Figure 1), and (2) the nation (Figure 2). The same 24 possible issues were offered for both questions and included an option to manually add an issue not listed. Issue options were based on the Homeland Security Exercise and Evaluation Program’s exercise evaluation tool for medical surge. A total of 84 surveys were completed (n = 84).