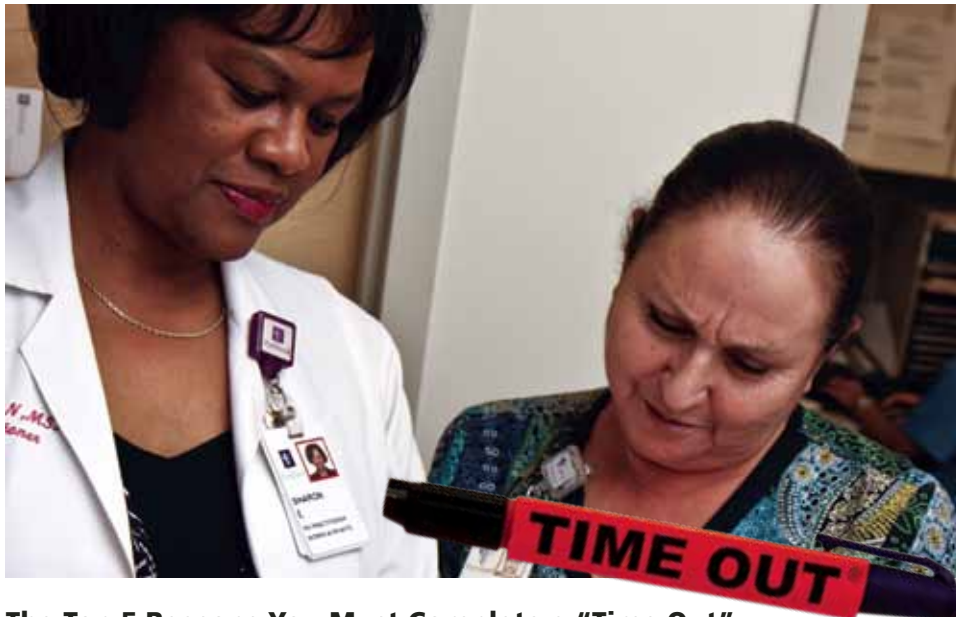


Clinical Care Connection



Parkland

Connecting Parkland's clinical staff with the latest information and patient care updates FEBRUARY 2011



The Top 5 Reasons You Must Complete a "Time Out"

5. The Joint Commission requires it

A "Time Out" is part of the universal protocol in the National Patient Safety Goals chapter of The Joint Commission Standards for Hospital Accreditation. The purpose of the universal protocol is to prevent wrong site, wrong procedure and wrong person surgery. The hospitals have some discretion in how the universal protocol is implemented, but The Joint Commission (TJC) does specify that consistent implementation of a standardized protocol is most effective in achieving safety. TJC further states that the three components of the universal protocol (pre-procedure verification, site marking and the time out procedure) should be as consistent as possible throughout the hospital system.

www.jointcommission.org

4. Parkland procedure requires it

Administrative Procedure 6-30 in the Patient Rights and Care Functions section describes how Parkland will implement the universal protocol. The purpose of this procedure is to promote patient safety by providing guidelines for verification of correct site, correct procedure and correct patient.

This procedure is more specific than TJC standard regarding which procedures require use of the universal protocol. With the few exceptions outlined in the procedure, all surgical and non-surgical invasive procedures require implementation of the universal protocol. Invasive procedures are further defined as any procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. This administrative procedure clearly describes the process to be followed for all three components of the universal protocol.

Continued on page 2

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3. It is evidence based best practice

Wrong site, wrong procedure and wrong person procedures can be prevented. It requires active involvement of all members of the procedure/surgery team. Best practice requires active participation in the universal protocol (pre-procedure verification, site marking and time out procedure) followed by accurate documentation of the process.

As outlined in Administrative Procedure 6-30, the time out should be performed immediately before starting the invasive procedure or making an incision in the location in which the procedure will be done. Active acknowledgement from all team members for correct patient, correct procedure and correct site (if applicable) is required. Initiation of the time out procedure is the responsibility of the licensed independent practitioner (LIP), licensed provider (LP), resident or fellow performing the procedure. This can be delegated to another team member if that individual is a routine member of the procedure team (circulator nurse or trained technician).

2. It saves time, resources and patient suffering

A common complaint is "I am too busy" to participate in the universal protocol. The truth is, you can't afford not to take the time for pre-procedure verification, site marking and time out. When done properly and routinely, none of the three components of the universal protocol are time consuming tasks. It can take longer to get the attention of all the team members than it does to actually complete the process. Consider the time that will be required to address a wrong procedure, wrong patient or wrong site. Then consider the pain and suffering of the patient, potentially the one who needed the procedure as well as the one who received the procedure but didn't need it. Then consider the possible permanent impact a wrong procedure, wrong patient or wrong site would have on a patient.

Administrative Procedure 6-30 does allow for a provider to waive the time out if he/she determines that the time out would interfere with the care of a life or limb threatening injury, adding more risk than benefit. The provider must document the rationale for the waiver in the medical record. However, even in the vast majority of emergency cases, a brief time out is recommended to verify correct patient, procedure and site. It is important to remember that the intent of the universal protocol is to protect the patient. With that in mind, all relevant team members must actively participate in the pre-procedure verification, site marking (if applicable) and time out procedure.

1. It is the right thing to do for the patient

Med-Surg Memos

Warning Signs of Suicide

Suicide can be prevented. While some suicides occur without any outward warning, most people who are suicidal do give warnings. Learn to recognize the signs of someone at risk, take those signs seriously and know how to respond to them.

Warning signs of suicide include:

- Observable signs of serious depression:
 - o Unrelenting low mood
 - o Pessimism
 - o Hopelessness
 - o Desperation
 - o Anxiety
 - o Withdrawal
 - o Sleep problems
- Increased alcohol and/or other drug use
- Recent impulsiveness and taking unnecessary risks
- Threatening suicide or expressing a strong wish to die
- Making a plan:
 - o Giving away prized possessions
 - o Sudden or impulsive purchase of a firearm
 - o Obtaining other means of killing oneself such as poisons or medications
- Unexpected rage or anger

Although most depressed people are not suicidal, most suicidal people are depressed. Serious depression can be manifested in obvious sadness, but often it is expressed as a loss of pleasure or withdrawal from activities that had been enjoyable.

Facts

More than 90 percent of people who kill themselves are suffering from one or more psychiatric disorders, in particular:

- Major depression (especially when combined with alcohol and/or drug abuse)
- Bipolar depression
- Alcohol abuse and dependence
- Drug abuse and dependence
- Schizophrenia
- Post Traumatic Stress Disorder (PTSD)
- Eating disorders
- Personality disorders

The core symptoms of major depression are a "down" or depressed mood most of the day or a loss of interest or pleasure in activities that were previously enjoyed for at least two weeks, as well as:

- Changes in sleeping patterns
- Change in appetite or weight
- Intense anxiety, agitation, restlessness or being slowed down
- Fatigue or loss of energy
- Decreased concentration, indecisiveness or poorer memory
- Feelings of hopelessness, worthlessness, self-reproach or excessive or inappropriate guilt
- Recurrent thoughts of death or suicide

Recognize the imminent dangers. The signs that most directly warn of suicide include:

- Threatening to hurt or kill oneself
- Looking for ways to kill oneself (weapons, pills, rope or other means)
- Talking or writing about death, dying or suicide
- Has made plans or preparations for a potentially serious attempt
- Past suicide attempt

Other warning signs include expressions or other indications of certain intense feelings in addition to depression, in particular:

- Insomnia
- Intense anxiety
- Pain or internal tension, as well as panic attacks
- Feeling desperate or trapped – like there's no way out
- Feeling hopeless
- Feeling there's no reason or purpose to live
- Rage or anger

Be willing to listen.

- Start by telling the person you are concerned and give him/her examples
- If he/she is depressed, don't be afraid to ask whether he/she is considering suicide, or if he/she has a particular plan or method in mind
- Ask if they have a therapist and are taking medication
- Do not attempt to talk someone out of suicide. Rather, let the person know you care, that he/she is not alone, that suicidal feelings are temporary and that depression can be treated. Avoid the temptation to say, "You have so much to live for," or "Your suicide will hurt your family"

In an acute crisis:

- If someone is threatening, talking about or making plans for suicide, these are signs of an acute crisis
- Do not leave the person alone
- Remove from the vicinity any firearms, drugs, rope or sharp objects that could be used for suicide
- Take the person to the Psych ER if at Parkland. If at home, take the person to the nearest psychiatric hospital

Corporate Compliance

When Your Interest is a Conflict

There is a saying, "Build a better mousetrap and the world will beat a path to your door." Ingenuity and innovation are what make America great. Many Parkland employees exhibit these attributes every day as they contribute to Parkland's mission of serving our patients. It's no surprise that some of these same motivated people use their skills outside of the hospital as business owners, partners or as employees operating, for example, their own home health agency, as a partner in a durable medical equipment company or as an employee for a medical billing agency.

While those pursuits are commendable, it's important to remember that you have a responsibility to avoid conflicts between your private interests and your Parkland duties. Employees are required to refrain from using any proprietary or non-public information that they acquire or have access to as a result of their relationship with Parkland for personal gain or for the benefit of another business opportunity. For example, accessing or taking patient information to develop personal client lists is not only a conflict of interest, but also a breach of patient privacy. Parkland will take appropriate action when it becomes aware of such activities which could lead to termination of employment, loss of professional license and potential criminal prosecution.

Parkland believes in the talents and abilities of its employees and supports those successful ventures and endeavors that are undertaken in the right way. Parkland is also committed to complying with all laws and regulations and ensuring that its business practices reflect the highest ethical standards. Personal and corporate integrity is one of Parkland's guiding principles and all members of the Parkland team, including employees, volunteers and members of the medical staff are expected to avoid any activities that may involve or may appear to involve a conflict of interest.

Please feel free to contact Corporate Compliance at ext. 21171 if you have any questions or need assistance identifying a potential conflict.



Learn to recognize the signs of someone at risk, take those signs seriously and know how to respond to them.



*Fascioliasis, caused by the liver fluke *F. hepatica*, is present worldwide but is most common in Western Europe, Northern Africa, South America and the Middle East.*

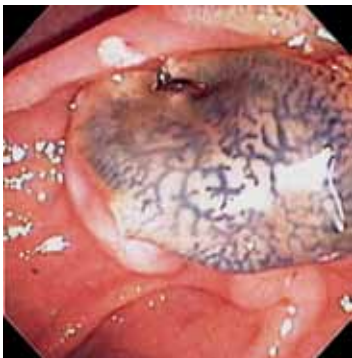


Figure 1



Figure 2

Laboratory Scope

Micro Fasciola Case Study

A 28 year old female presented to Parkland at 36-37 weeks of gestation with nausea, vomiting and right upper quadrant abdominal pain. Laboratory studies at the time were significant for an AST of 76 U/L, ALT of 61 U/L, total bilirubin of 1.9 mg/dl and direct bilirubin of 0.6 mg/dl. An abdominal ultrasound revealed cholelithiasis and possible choledocholithiasis. As the patient was stable, surgical management was postponed until after delivery. Shortly thereafter, a healthy infant was delivered by caesarean section and the patient's initial postpartum course was uncomplicated.

Three weeks postpartum, she presented again with similar symptoms with the addition of mild scleral icterus. Laboratory testing was significant for the following: AST 237 U/L, ALT 267 U/L, total bilirubin 4.5 mg/dl, direct bilirubin 2.1 U/L and peripheral eosinophilia of 9.3 percent. A repeat abdominal ultrasound showed possible cholelithiasis and a contracted gallbladder suggesting chronic cholecystitis. IV antibiotics and fluids were begun and Gastroenterology was consulted. Endoscopic retrograde cholangiopancreatography (ERCP) was performed revealing dilated extrahepatic bile ducts, an opaque gallbladder and cystic duct and several small filling defects not characteristic of gallstones. The filling defects could be seen moving on their own in the ducts. A sphincterotomy was performed and three worms were captured in a small net and removed. One of the worms is shown in the lumen of the small bowel in Figure 1. The worms were submitted to the Microbiology lab where they were identified as adult forms of *Fasciola hepatica*.

Stool was also submitted for ova and parasite examination and large, operculated eggs of *F. hepatica* were identified (Figure 2). Based on the recommendations of Infectious Disease the patient was treated with triclabendazole. Two months after therapy, the patient's liver function tests returned to normal and stool ova and parasite examination was negative.

Fascioliasis, caused by the liver fluke *F. hepatica*, is present worldwide but is most common in Western Europe, Northern Africa, South America and the Middle East. It is an important pathogen in herbivores and it is estimated that approximately 2.4 million people are infected worldwide. However, human cases are rare in the U.S. and the vast majority are imported from endemic areas. Infection occurs through ingestion of aquatic vegetation (classically watercress) or water contaminated with the encysted larval stage of the parasite. In the intestine, the cyst opens, releasing the larva which then penetrates the bowel wall, enters the peritoneal cavity and makes its way to the liver. As the larvae migrate through the liver they begin to mature and eventually reside in the bile ducts as adults. They are hermaphrodites and the eggs they produce are passed in the feces to complete their life cycle, which includes a certain fresh water snail as an intermediate host. The larvae released from the snail encyst on aquatic vegetation and once ingested by an animal or human, continue the cycle. The patient was questioned about her dietary habits but a source for her infection was not identified.

The laboratory diagnosis of fascioliasis can be facilitated by a combination of serology for antibody detection during the acute and chronic phases of infection and stool examination during the chronic phase.

Respiratory Tidings

Potential Complications Associated with BiPAP Therapy

BiPAP is a non-invasive form of mechanical ventilation most often used in the acute care setting to prevent intubation. Although considered safer than invasive ventilation, patients placed on BiPAP require frequent assessment to maintain safety and ensure success. As such, clinicians caring for patients receiving BiPAP therapy should have an understanding of the potential complications and demonstrate the ability to perform an adequate patient assessment targeted at minimizing those complications. Listed below are potential complications associated with BiPAP:

Risk of Aspiration

- The risk is rare, however it is increased when using a mask that covers the mouth and nose (full mask)
- This risk can be minimized by limiting inspiratory pressures to < 20 cm H₂O
- Frequent assessment for gastric distension should be performed
 - o This is of special clinical importance when a full mask is used for patients with acute respiratory compromise
 - o Although rarely needed, a nasogastric tube can be placed if necessary

Issues associated with the Mask

- Facial Pressure Sores
 - o Usually occur on the bridge of the nose
 - o Pressure sores may begin occurring as little as one hour after BiPAP initiation
 - o Pressure sores can be prevented by allowing small mask leaks and limiting the pressure of the mask on the face
 - o Assessment for pressure sores associated with the mask interface should be performed routinely
 - o If signs of a pressure sore appear, notify the respiratory therapist immediately

Excessive mask leaks

- Almost all patients on BiPAP will have a leak from the mask, this is normal
- Efforts should be made to keep leaks from blowing into the patient's eyes
- Leaks that are too big will make it difficult for the patient to breath with the machine and the respiratory therapist should be notified
- If the patient is not achieving the ordered IPAP level the leak may be too large

Nursing Informatics

EPIC Documentation

This is a reminder that there is a Nursing Policy (13-08) for making changes/corrections to your nursing notes. This is being updated to reflect EPIC charting. The .tds format should be used to start each new note.

"If an error is made in charting, draw a line through the error with initials, leaving the original entry legible. Place the corrected entry above the error if possible...Corrections in EPIC retain the original entry, viewable in the audit trail.

"A note that is out of sequence will be labeled as a late entry. The date and time of entry will be recorded. The date and time the observation/activity took place will be recorded."

Blood products and derivatives (such as albumin) are documented on the Blood Transfusion flowsheet in the Doc flowsheet. Blood is documented as "new bag" under the action field in the Blood Administration Record. The correct unit number (with the check digit) must be documented. Derivatives are documented as "derivative/factor" and no unit number is needed. If you want to enter the lot number, you can document it in the comments section of the BAR. Just as previously documented on paper, please put started and completed times for each.

Cryoprecipitate comes from the blood bank as two bags and each bag has a different unit number. So there must be two releases to the Blood Administration flowsheet. The order has been changed to make it easier for the provider to indicate that there will be two infusions for each order.

Remember that if EPIC isn't working the way you think that it should, let someone know. Put in an ITSM ticket, talk to your manager or your Superuser. We can't fix things unless we know they are broken.

Outpatient Observations Be All That You Can Be

This statement is easily identified as the marketing slogan used by the United States Army. In the army, being all that you can be is associated with principles such as courage, respect, discipline and honor. Throughout history, soldiers who have adopted these principles have conquered their enemies and have provided a great service to their country and those who live within it.

You might consider Parkland's "CIRCLES of Life" as our marketing slogan. The "CIRCLES" consist of compassion, integrity, respect, collaboration, leadership, excellence and stewardship. When employees adopt these principles and the evidence of these principles show in their daily duties, they are representing Parkland much in the way that American soldiers represent our country. As you read the definitions of Parkland's "CIRCLES" that are provided below, ask yourself if you are willing to be all that you can be.

Compassion - A deep awareness of and sympathy for another's suffering

Integrity - Moral soundness

Respect - Proper acceptance or courtesy; acknowledgment

Collaboration - To work jointly with others or together especially in an intellectual endeavor

Leadership - The office or position of a leader

Excellence - Extremely high quality

Stewardship - The careful and responsible management of something entrusted to one's care



Safety Stop

Waste Minimization is a Parkland Guiding Principle - Stewardship

Every department at Parkland generates waste. For some, it may be only office paper. For others, it may be hazardous or toxic waste that requires special handling and disposal. Instituting waste minimization at the department level is a matter of good, sound business practice. Each department should have a goal to reduce waste, facilitate compliance with environmental regulations, outline the structure for managing their waste minimization program and help department personnel manage a waste minimization program.

Nationally, waste minimization programs have contributed positively to the bottom line of companies that have chosen to implement them. In summary, minimizing waste will:

- Reduce environmental impacts
- Promote environmental stewardship
- Increase hospital profitability

Leaders and employees at all levels should look for innovative new ways to reduce waste disposal in their areas. Here are a few basics:

Know Your Waste - To successfully reduce or minimize waste generation, you must first understand why the wastes were created, where they arise, the special waste handling processes for worker and public safety, regulatory compliance governing the handling of the waste stream and the varying costs of handling, treating and disposing of these wastes. The following represent the six major waste streams generated within hospitals:

- Liquid wastes
- Solid wastes
- Hazardous wastes
- Radioactive wastes
- Air emissions
- Medical wastes

Segregate Your Waste - Regulators classify mixed waste and specify the required manner of its disposal according to the most highly regulated component in the mix. Thus, solid waste mixed with medical waste is classified as medical waste and hospitals must dispose of it as such. This may increase the cost of disposal by 20 times more than the cost if the waste streams had not been co-mingled.

Select Your Waste Container Locations - One of the most important factors in reducing medical waste is "location" of the medical waste container. Medical waste containers placed next to sinks will inevitably collect paper towels and other solid waste. Department employees must be properly trained as to placement of the containers in order to curtail improper disposal of solid waste. Department staff that generate medical waste must also be trained in the need to keep solid waste out of the medical waste stream.

Limit Your Use of Chemicals - The use of chemical dispensing units at Parkland can reduce the amount of chemicals used by removing the "human factor" in "eye-balling" the quantity of chemicals to be used. For example chemical dispensing units have been installed within janitor's closets where chemical-using equipment is filled. Different sized dispensing heads meter out a measured amount of chemicals as required for the cleaning procedure being performed. Parkland realizes cost savings by reducing the amounts of chemicals used.

Be a good steward - help minimize waste within your department.

Clinical Staff Services

Attend Upcoming Seminars

Attend the seminar "Stroke: Managing Its Victims" from 8 a.m. to 4:30 p.m., Wednesday, March 9 in MacGregor W. Day Auditorium. This activity is worth 6.75 contact hours for nurses. There is another seminar, titled "Nursing & Geriatrics: A New Challenge" from 8 a.m. to 4:30 p.m., Wednesday, March 23 in MacGregor W. Day Auditorium. This activity is worth 7.0 contact hours for nurses.

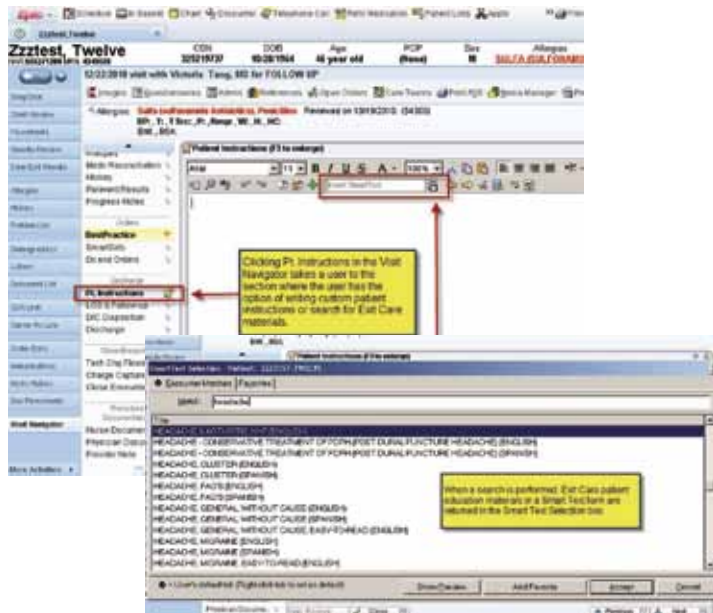
Pharmacy Formulary Updates

Thrombin (Recothrom™)	Remain Nonformulary
Fibrin Sealant (Artiss)	Formulary Addition with Restriction Restrict to the Burn Service for graft adherence in pediatric patients and for sheet graft adherence in adult patients.
Ropivacaine (Naropin®)	Restriction Change Ropivacaine is restricted to use by Anesthesia & Pain Management Service. Ropivacaine's use as an infusion in upper and lower extremity peripheral nerve blocks and epidurals is restricted to Pain Management Service.
Fospropofol (Lusedra™)	Remain Nonformulary
Azelastine (Astelin®)	Formulary Addition with Restriction All initial prescriptions, refills and renewals restricted to the following clinics or services: Asthma/Allergy and ENT following failure of intranasal corticosteroids and oral antihistamines.
Tiotropium (Spiriva®)	Restriction Change Tiotropium can be prescribed by any physician under the following conditions: Diagnosis of COPD with the following post-bronchodilator pulmonary functions: FEV1/FVC <70 percent, FEV1 <65 percent of predicted value AND at least one of the following: ≥ 2 COPD exacerbations requiring urgent or emergent care OR ≥ 1 exacerbation requiring hospitalization in the last year.
Advair 100/50	Restriction Change only for NEW STARTS Advair 100/50: Initial prescriptions restricted to failure of QVAR 80 mcg for two consecutive months within the past six months. For continuation of therapy and refills, continue Advair 100/50. This is not an autoexchange. *Make sure the patient has a valid RX for short acting B2 agonist on profile.
Leuprolide (Lupron®)	Expanded Use Approved for use in fertility preservation for rheumatology patients requiring cyclophosphamide. The recommended dose and formulation is the 3.75mg IM monthly while receiving chemotherapy.
Aprepitant (Emend®)	Formulary Addition with Restriction For Chemotherapy Induced Nausea and Vomiting (CINV) per institutional guidelines. Approved first line regimen for highly emetogenic risk chemotherapy. For moderately emetogenic chemotherapy, Aprepitant will be restricted to failure of standard treatment.
Capsaicin (Qutenza™) Patch 8 percent	Remain Nonformulary
Darbepoetin (Aranesp™)	Restriction Change Reduce the hemoglobin goal range from 11-12 g/dL to 10-12 g/dL.

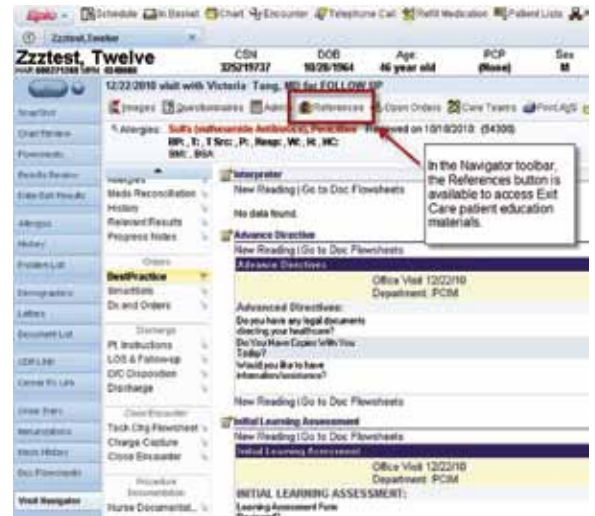
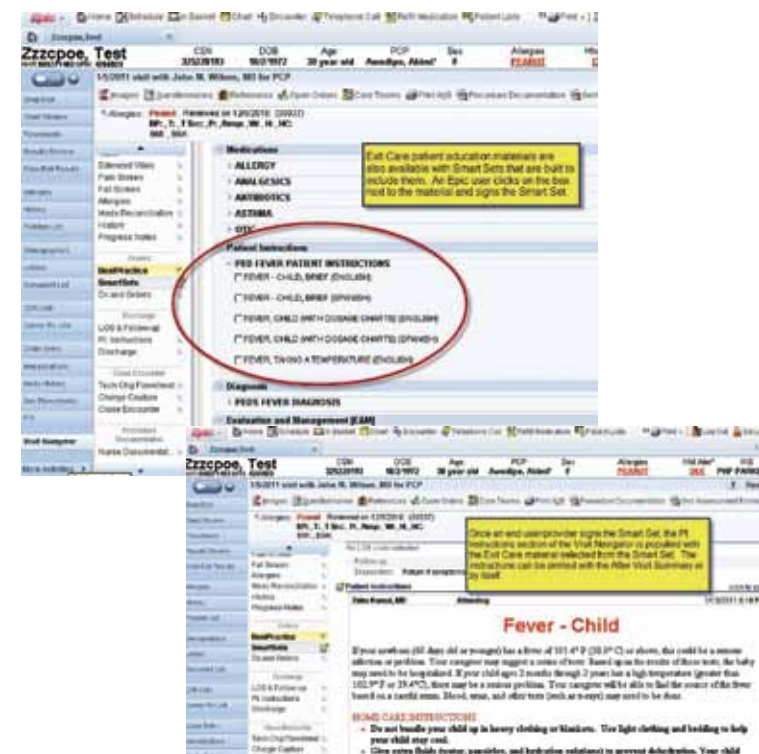
Target date for Formulary implementation: March 1

Patient Education Update Accessing ExitCare Patient Education Materials from EPIC in the Ambulatory Clinics

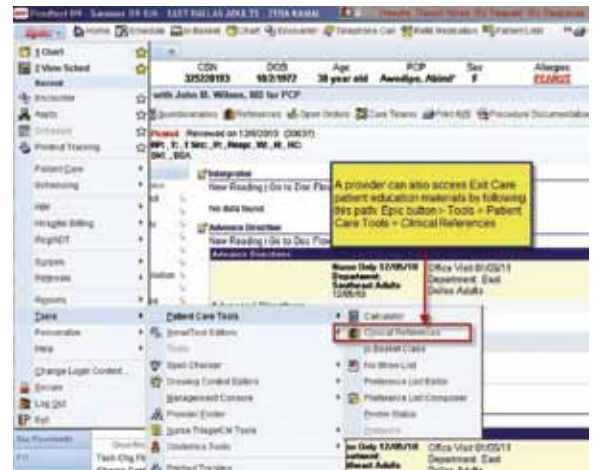
The December issue of the *Clinical Care Connection* discussed the process for accessing ExitCare patient education materials through EPIC in the inpatient setting following the December 2010 EPIC upgrade. This month we address the ways ExitCare can be accessed through EPIC in the ambulatory clinics.



- Looking up ExitCare materials from the Patient Instructions section of the Visit Navigator



- ExitCare materials can be accessed from the References tab in a patient's workspace



- Using the EPIC button to get to Clinical References by following the path: EPIC button > Tools > Patient Care Tools > Clinical References

- The material populates Patient Instructions when a Smart Set is signed by a provider/user

- Selecting patient education materials built into Smart Sets: The material populates Patient Instructions when a Smart Set is signed by a provider/user

Continual Readiness

'Texas Health Steps' a Cornerstone in COPC Clinics

Later this year Parkland will undergo a week long survey from Texas Department of State Health Services (DSHS). The survey will involve many of our community health services, including Texas Health Steps. The Texas Health Steps program (THSteps) is Medicaid's comprehensive preventive child health service and is offered to individuals from birth through 20 years of age. Texas Health Steps is instrumental in reducing risk factors and growing healthy adults. This program has been the cornerstone of child health and is offered in the Parkland community clinics.

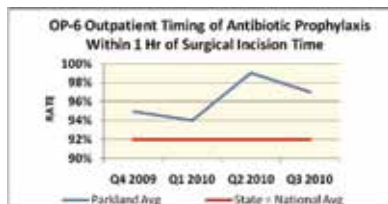
Below is a summary of the required components of a Texas Health Steps medical checkup which must be documented in the medical record as a condition of reimbursement by Medicaid.

- **Comprehensive Health and Developmental History** - This includes screening of both physical and mental health development. The initial history must include the family medical history, neonatal history, the child's physical and mental health and developmental history, immunization history, nutrition and tuberculosis screening
- **Nutritional Screening** - Dietary practices should be assessed to identify unusual eating habits, including extended use of the baby bottle or eating disorders in children and adolescents. The checkup must include a quality and quantity determination of the child's diet
- **Developmental Screening** - A developmental and autism screening must be performed for each age-appropriate group based on the type of screening tool the physician chooses to use
- **Mental Health** - An emergency mental health referral for evaluation and/or treatment must always be made when suicidal thoughts, threats or behaviors and/or homicidal thoughts, threats or behaviors are identified during a mental health screening
- **Tuberculosis (TB) Screening** - Administration of the PPD and screening the patient for TB is required based on age and/or risk
- **Laboratory Screening** - Requires lead toxicity screening, blood lead level appropriate to age and risk, total hemoglobin or hematocrit or others based on risk identification such as hyperlipidemia
- **Health Education** - Health education and counseling including anticipatory guidance must be face-to-face with the child's parent(s), caretaker(s) or guardian
- **Comprehensive Unclothed Physical Examination** - A complete physical examination is required at each visit with infants totally unclothed and older children unclothed and suitably draped. The physical examination should include all the components listed below:
 - o **Measurements** - Requires documentation of height, head circumference and length, weight for children and body mass index (BMI). Blood pressure checks at 3 years of age and every year thereafter. All measurements and blood pressure should be compared with the National Center for Health Statistics growth charts to identify significant deviations from norms
 - o **Sensory Screening**
 - o **Vision/Hearing Services** - This requires subjective and objective screening at various ages. Documentation of test results from a school vision or hearing screening program may replace the required objective screening if they are conducted within 12 months before the checkup
 - o **Dental Services** - Limited dental screening for cavities and general health of the teeth is part of the physical examination. In addition to the federal requirements, Texas requires referral to a dentist at 6 months of age and every six months thereafter
 - o **Immunizations** - Age appropriate screening and administration of immunizations should follow the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. Parents may refuse immunizations based on reasons of conscience, including religious beliefs

For more information on the Texas Health Steps program visit the DSHS web site at <http://www.dshs.state.tx.us/thsteps/default.shtm>.

Shalini Raiasekaran, MD
Garland Health Center





Performance Improvement

Have You Heard of SCIP for Outpatient Measures?

Many of you have heard of Surgical Care Improvement Project (SCIP) core measures for inpatients, but may be unaware of SCIP outpatient core measures. Two outpatient SCIP core measures have been defined and are currently tracked like the inpatient cases through United Health Care Consortium (UHC). These measures are:

- **OP-6** - Timing of antibiotic prophylaxis initiated within one hour prior to surgical incision time
- **OP-7** - Prophylactic antibiotic selection for surgical patients

Multiple evidence based studies have demonstrated that proper selection of antibiotics and correct timing contributes to better patient outcomes. It has been shown that antibiotic delivery just before surgical incision is the most important factor in reducing surgical site infection rates.

Parkland is an early performer in reporting outpatient measures to UHC and is a top performer on both measures over the past year. OP-6 and OP-7 have both exceeded the national and state compliance rates according to the Hospital Outpatient Department Quality Measures; Parkland's average for the year on OP-6 is 94 percent and for OP-7 is 100 percent. The graph on the left shows Parkland's compliance rates for the past year for OP-6 and OP-7 relative to the state and national averages for the same time period.

As we continue to strive for perfection, leadership in the outpatient departments will receive information on any cases that do not pass the audit in order to correct any deficiencies. Quality goals for SCIP outpatient measures will be set in the future. Congratulations to all who work hard to help keep our patients protected from infections.

Patient Safety and Risk

2011 NPSGs Are Out

The Joint Commission has recently released the 2011 National Patient Safety Goals (NPSGs). There are no significant changes to the goals this year. As a reminder, the NPSGs are:

- **Patient identification** - Use two patient identifiers when providing care (name and date of birth)
- **Improve communication** - This applies to critical results. For lab results utilize the critical result flowsheet for documentation of required elements; time result received, time provider notified, name and/or ID of provider, intervention received if any
- **Improve safe use of medications** - This includes labeling medications once removed from their original package. This applies to medications given both on and off a sterile field. This also includes monitoring patients on anti-coagulant therapy as well as always giving IV anticoagulants on an IV pump. Also added will be standardization around medication reconciliation. Review of the patient's medications on admission and discharge is required
- **Reduce the risk of health care associated infections** - Wash your hands
- **Prevent the spread of multi-drug resistant organisms** - This applies to organisms like MRSA, VRE and C. Diff. Use contact isolation appropriately and educate patients and families about their disease
- **Prevent central line associated bloodstream infections** - Scrub the hub and use the central line bundle when inserting central lines
- **Prevent surgical site infections** - Education on prevention and signs and symptoms of infections is provided to patients and families. Follow pre-surgical protocols
- **Identify patients at risk for suicide** - This applies to all patients, not just those in psych areas
- **Use Universal Protocol to prevent wrong site, wrong procedure, wrong patient surgeries** - Mark the site when applicable and ensure a time out is done prior to any invasive procedure or surgery by all members of the team

2011 NPSG posters will be completed and distributed to your areas soon. All of these basics of everyday care provide additional opportunities to help keep our patients safe. Call Patient Safety & Risk at ext. 21780 with questions or page the Risk Management Analyst on call through Smart Web.

March to Magnet Designation

Critical Value Result Documentation, Critical Values Issues Resolution

The 2011 National Hospital and Laboratory Patient Safety Goal 2 is to improve the effectiveness of communication among caregivers; specifically targeting and reporting critical results of tests and diagnostic procedures on a timely basis.

The rationale for this goal is that critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

You must have:

- Time provider notified (has to be less than 30 minutes from the time the nurse was notified by the lab)
- Documentation of result
- Provider name with credentials and/or ID number
- Intervention

Documentation Tips:

- Critical value results cannot be sent via text page as there is no way to document that the doctor received the result or the time received. Text pages can be sent to surgeons in the OR or to other doctors to call the unit for critical value results
- Chart all aspects of the critical value notification and intervention on the critical value flowsheet, not in the nurses' notes
- Use the drop down lists on the flowsheet to complete all the required elements
- When adding comments in the intervention section, click on "other" before adding the written comments
- Use the escalation procedure written in Administration Procedure 6-28 for residents that are not responding to a page

The Nurse Practice Council continues to address documentation and practice issues affecting nursing at Parkland as we advance shared governance and continue our "March to Magnet." If you have an issue affecting nursing across the institution, please contact Venita Dasch or Jan Sumner, chair Nurse Practice Council at ext. 29110 or via e-mail at NursePracticeCouncil@phhs.org.

WISH List

Magnet and WISH

Parkland is on a journey we call "Marching to Magnet." Each of us has a role in facilitating positive change to achieve this goal. There are 14 "Forces of Magnetism" that have been described as the heart of the Magnet Recognition Program^{®1}.

Force 8 - Consultation and Resources says "the health care organization provides adequate resources, support and opportunities for the utilization of experts, particularly advanced practice nurses. In addition, the organization promotes involvement of nurses in professional organizations and among peers in the community."

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) is a professional organization that encompasses all areas of WISH. In order to achieve our goal of magnet status, familiarizing yourself with and joining a professional organization such as this is a necessity. This is an easy step we can all take and feel proud that we have been a facilitator of change. Join a professional organization and encourage someone else to do the same. Great opportunities are in front of us, we all have to have the courage to take that first step. To learn more about AWHONN, visit www.awhonn.org. To learn more about the Magnet Recognition Program[®], visit www.nursecredentialing.org.

Reference:

1. <http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>

Pain Points

Propoxyphene Withdrawn from US Market

(Medscape Medical News)

The US Food and Drug Administration (FDA) has withdrawn propoxyphene (Darvon and Darvocet) from the market. Other manufacturers of generic propoxyphene and propoxyphene-containing products are also affected.

New clinical data shows that propoxyphene puts patients at risk for potentially serious or even fatal heart rhythm abnormalities.

The FDA is advising health care professionals to stop prescribing the drug. Patients who are currently taking the drug should not abruptly stop their medication but should contact their physician as soon as possible to discuss switching to another pain medication. An estimated 10 million patients have used this product.

According to Dr. Gerald Dal Pan, director of the Office of Surveillance and Epidemiology, "Long-time users of the drug need to know that these changes to the heart's electrical activity are not cumulative. Once patients stop taking propoxyphene, the risk will go away."

Propoxyphene is an opioid prescribed for mild to moderate pain and was first approved by the FDA in 1957. Since 1978, the FDA has received two requests to remove propoxyphene from the market. In Europe, the drug is being phased out by the European Medicines Agency's decision in June 2009.

Results of a recent propoxyphene safety study, combined with new epidemiologic data and medical examiner reports, show that the drug's risks outweigh its benefits.

Critical Care Vital Signs

New Changes in CPR and ACLS Guidelines

The American Heart Association (AHA) released new resuscitation guidelines in October 2010. It will take several months to implement these changes, so for the immediate future CPR and ACLS classes will still use the previous guidelines. Although the guidelines are published, textbooks and new tests will not be available from AHA until spring or summer. Until that time, there are insufficient materials to teach the new standards. CPR books/tests are expected to be released by the end of March and ACLS books/tests by the end of June.

If you are interested in learning more about the upcoming changes, go to http://circ.ahajournals.org/content/vol122/18_suppl_3/.

For a quick overview of the major changes:

CPR

- New order for beginning is "C-A-B:" Chest compressions, Airway, Breathing
- The old way was "A-B-C." The new focus is on chest compressions. Many people are hesitant to do mouth to mouth ventilation which could delay the start of CPR. Beginning with chest compressions may alleviate this problem. Better outcomes are associated with the earlier/quicker start of chest compressions

ACLS

- Atropine is no longer recommended for routine use for bradycardic PEA arrests. Studies suggest that atropine used to treat PEA or Asystole is unlikely to have any therapeutic benefit
- Adenosine can be given for the initial diagnosis of stable, undifferentiated, regular, monomorphic wide complex tachycardia (text book normal VT)
- There are new guidelines for post cardiac arrest care, including recommendations for therapeutic hypothermia to optimize neurologic recovery

UAP Exclusive

Medical Terminology

The Gastrointestinal System (GI tract) consists of eight major structures and three accessory organs. It is responsible for breaking down and absorbing the food a person eats. Remember that when words are broken down into their root, prefix or suffix, their meaning becomes clearer.

Take the word gastrointestinal. Broken down it becomes:

- Gastr/o – meaning *stomach*
- Intestin – meaning *intestine*
- -al – meaning *pertaining to*

So when we see the word gastrointestinal, by breaking it down into smaller parts, we are able to see that it means "pertaining to the intestine and stomach."

The major structures of the GI tract are divided into the upper GI tract and the lower GI tract. The upper GI structures are the mouth, esophagus and stomach. The lower GI structures are the small and large intestines, rectum and anus.



Word roots of major structures and examples:

Oral cavity (mouth) – or/o	<i>oral</i>
Pharynx (throat) – pharyng/o	<i>pharyng-eal, pharyng-itis</i>
Esophagus – esophag/o	<i>esophag-eal</i>
Stomach – gastr/o	<i>gastr-ic</i>
Small intestine – enter/o	<i>entero-stomal</i>
Large intestine – col/o	<i>colo-stomy, colono-scopy</i>
Rectum – an/o	<i>anal</i>
Anus – proct/o	<i>procto-logy, procto-logist</i>

The accessory organs of the GI tract are the liver, gallbladder and pancreas. Accessory means that they are aiding, contributing or associated in a secondary way to the functions of the GI tract.

Word roots of accessory organs and examples:

Liver – hepat/o	<i>hepat-ic, hepat-itis</i>
Gallbladder – cholecyst/o	<i>cholecyst-ectomy, cholecys-titis</i>
Pancreas – pancreat/o	<i>pancreat-ic, pancreat-itis</i>