Clinical Care Connection

Parkland

Connecting Parkland's clinical staff with the latest information and patient care updates May 2010

Handwashing is an important aspect of ensuring safe, quality care.

What is Continual Readiness?

Nearly a year ago, Parkland embarked on a different approach to expectations for meeting the regulatory and accreditation standards in the delivery of patient care.

The Continual Readiness program is proactive and patient centered. A committee of leaders and teams was established to review and score compliance with the required standards of care. The Continual Readiness staff is out and about in all clinical areas of the Parkland system doing observation rounds and patient tracers. These activities focus on recognizing best practices as well as opportunities for improvement, and have already made a difference in staff knowledge, participation and awareness of how the standards are met while caring for patients.

Patient tracers are a review of the patient's experience while in our care. A tracer can be disease or service specific and is a review of any of the services and caregivers a patient encounters while at Parkland, with a focus on quality, safety and timeliness of the care received.

Reminder: some simple but important things to do that will ensure patients receive safe, quality care:

- Wash your hands
- Know your patient – always check the two patient identifiers
- Communicate with other caregivers about the patient (hand-offs)
- Know how to find the patient's information in electronic and paper medical records
- Know about the projects your unit is working on to improve patient care (PI)

Continual Readiness is being patient-centered every day, in every way.

In this issue

Lung Navigator, Sharon Goldman, RN, pictured left, explains care to a patient in Parkland's Oncology Clinic.

The navigator's goals are to: fast track the patient's access to consultation and diagnostic testing, reduce timing between diagnosis and treatments, increase the patient's compliance to treatment as well as completion of treatment.

Performance Improvement

Patient Navigator—Improving Outcomes of Lung Cancer Patients Treated at Parkland

The role of the Oncology Nurse Navigator is just one more strategy used by Parkland to ensure "Patient Focused Care." The role of the navigator is not a new concept and is not unique to Parkland. But Parkland has stepped up to the plate to ensure an infrastructure designed to further manage access barriers along with the complexities related to cancer care. The Parkland approach to cancer care is through integrated multidisciplinary programs. Multidisciplinary care is the coming together of all specialists related to a particular cancer to discuss the patient's options to identify the best care plan. Clinical integration is a service delivery method that requires bringing together a critical set of people (health professionals, social service staff, etc.) to care for the patient either concurrently or at different points in time in different service areas.

The navigator's role was developed to help the patient through this process by acting as a liaison for the patient and families with physicians and other care providers. Navigators will assist patients and families to overcome barriers to access, to educate, to coordinate appointments and other services and to help patients and families access other cancer related resources. The navigator relationship with patients and families is designed to continue throughout the entire cancer journey.

The navigator's goals are to: fast track the patient's access to consultation and diagnostic testing, reduce timing between diagnosis and treatments, increase the patient's compliance to treatment as well as completion of treatment.

There are several existing navigator models and no one model has yet demonstrated a clear advantage. Parkland uses a combination of models and through this strategy has been able to successfully cover all major disease sites. For further information please contact:

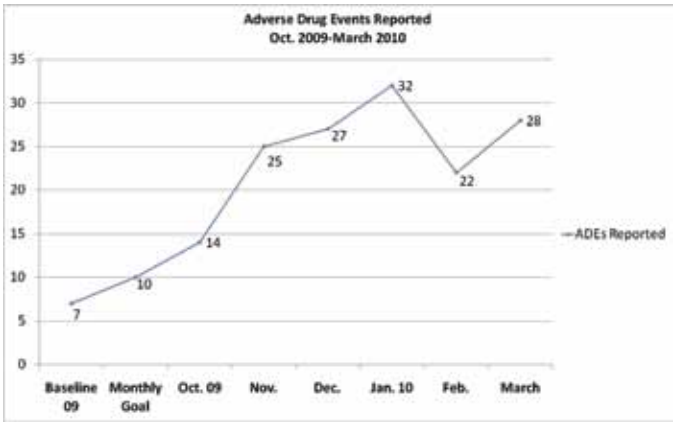
Carol Pearson, Hematology/Oncology Manager	**214.590.5587**
Sharon Goldman, RN, Lung Navigator	**214.590.5312**
Peggy Gilbert, RN, GI/GU Navigator	**214.590.5313**
Sandy Lindsey, RN, Hematology (Benign & Malignant)	**214.590.5324**
Lisa Lilly, NP, Breast Navigator	**214.590.5303**
Alisha Hill, Breast Navigator	**214.648.1644**

Pharmacy Forum

Why Report Adverse Drug Events (ADEs)?

An adverse drug event (ADE) is any undesirable or unexpected response to a drug that occurs at doses normally used for the prophylaxis, treatment or diagnosis of a disease and requires specific medical intervention. More than 700,000 people are injured or die yearly due to an ADE, and patients experiencing an ADE have their hospitalizations extended by an average of 8 to 12 days compared to patients who do not suffer an ADE. Depending on the size of the hospital, ADEs can cost up to $5.6 million per year.

Reporting ADEs is important to help prevent the recurrence of harm and to ensure patient safety. The steps to reporting an ADE are simple. First, stabilize the patient and notify the physician and pharmacist. Finally, the ADE should be entered into the Patient Safety Net (PSN) located on the Intranet (http://intranet.pmh.org/Home/UHC/UHC.asp). If you are unsure of whether the patient suffered an ADE, still report it in the PSN. ADEs are reviewed to target opportunities for performance improvements; therefore ensuring patient safety. The graph to the right illustrates the monthly ADE reports from the PSN.



References:
http://www.ahrq.gov/qual/aderia/aderia.htm (Accessed April 12, 2010)

Pharmacy & Therapeutics Updates from the April 1 P&T meeting

Tip® Device with 1% Buffered Lidocaine	Formulary Addition with Restriction Restricted to Burn Service (BICU/BACU) and the Emergency Department for use in pediatric patients requiring IV cannulation Implementation to be determined
Pneumococcal Conjugate Vaccine – 13	Formulary Addition Implementation to be determined
Pneumococcal Conjugate Vaccine – 7 (Prevnar®)	Formulary Deletion
Argatroban	Restriction Change Restricted to Hematology Consult for patients with type II heparin induced thrombocytopenia (HIT) or the Cardiac Cath Lab for patients with type II HIT. In an emergent situation where there is not time to call Hematology prior to starting the medication, it may be started at the same time that a mandatory, concurrent page to the Hematology service is made.
Lepirudin	Restriction Change Restricted to Hematology Consult for patients with type II heparin induced thrombocytopenia (HIT) or the Cardiac Cath Lab for patients with type II HIT. In an emergent situation where there is not time to call Hematology prior to starting the medication, it may be started at the same time that a mandatory, concurrent page to the Hematology service is made.

The online Parkland Drug Formulary can be found at http://www.crlonline.com.
Target date for implementation: May 18

Care Management Corner

Allscripts Implementation

The Care Management department has moved forward with the implementation of the Allscripts Solution to aid in the discharge planning process and provide our patients with continuity of care. Allscripts went live March 29.

After World War II, government and private organizations began setting up education programs to stem the tide of abuse and addictions.

Pain Points

Good Medicine, Bad Behavior: Drug Diversion in America

The following information appears on the DEA website as part two of an exhibit.

The History of Prescription Drugs
A Mid-Century Drug Store (1950s- 1970s)

After World War II there was an amazing development of new medicines: tranquilizers, new amphetamines and barbiturates and new opioids (synthesized opium products). Weight loss products are sold containing amphetamines and ephedrine. National marketing of these medicines increased their use. This post-war era brings with it affluence, social change and mass use of medicines and drugs. Many of the stimulant, tranquilizer and sedative medicines are misused. Amphetamines and barbiturates are called "mother's little helpers" as many women develop a habit for the stimulation and sedative effects of these medicines. The predecessors to the modern Drug Enforcement Administration and other government and private organizations begin setting up education programs to stem the tide of abuse and addiction.

1951 – The Durham Humphrey Bill sets up prescription and non-prescription categories for all medicines. This arrangement of prescription vs. over-the-counter (OTC) is in place by policy and is then made law. It also sets up limits on the number of times a prescription can be refilled.

1955 – Tylenol introduces Acetaminophen. It finds widespread use and becomes the country's main OTC pain reliever. It is safer than aspirin when given to children.

1956 – The Narcotics Control Act updates restriction and penalties for smuggling and distribution of marijuana and narcotics. This eliminates the suspension of sentences or probation if convicted.

The Harrison Narcotics Act sets up a schedule using letters to indicate the degree of potential abuse a medicine has. The schedule uses A, B and X in a decreasing level of potential abuse.

1960s – The Manufacturing Act. Its purpose is to tighten controls and restrictions over legally manufactured narcotic medicines. This law requires that manufacturers are licensed and creates quotas for classes of both natural and synthetic medicines.

The Bureau of Drug Abuse Control is formed in the Food and Drug Administration to control non-narcotic medicines that are being abused. FDA undercover agents investigate abuse of amphetamines by truck drivers. In 1968, that bureau merges with the Federal Bureau of Narcotics to form the Bureau of Narcotics and Dangerous Drugs in the Department of Justice.

Advertisements in popular magazines assure the patient that potent medicines are safe to use.

1962 – The White House Conference on Narcotic and Drug Abuse was a response to increased narcotic medicine and drug abuse. The conference eventually leads to the Comprehensive Drug Abuse Prevention and Control Act of 1970.

1963 – The President's Advisory Commission on Narcotic and Drug Abuse produces the 1965 Federal Drug Abuse Control Amendments. The new rules require registration of manufacturers, wholesalers and other establishments. These entities, plus pharmacists and physicians, are required to increase record keeping of controlled substances. Marijuana is placed on the same level as narcotics.

1970 – The Comprehensive Drug Abuse Prevention and Control Act is a United States federal law that, with subsequent modifications, requires the pharmaceutical industry to maintain physical security and strict record keeping for certain types of medicines. Controlled substances are divided into five schedules (or classes) on the basis of their potential for abuse, accepted medical use and accepted safety under medical supervision. The medicine bottles have a C with the schedule number on the side.

1973 – The Drug Enforcement Administration is formed in the Department of Justice from other existing enforcement units in the U.S. government. Many agents from these other agencies move to the DEA.

1970s – The Office of Compliance, started in 1971, is renamed the DEA Office of Diversion Control.

Safety Stop

Chemical Spill in my Department! Now What?

Parkland has almost 5,000 chemicals in its written inventory. Many of them are hazardous and it is probable that a spill could unexpectedly occur in your workplace sooner or later.

Therefore, it is very important that each employee be familiar with the chemicals in their workplace. All employees must be provided information and trained prior to initial assignment to work with a hazardous chemical and whenever the hazard changes.

Remember, the management of chemicals is a department responsibility; this includes spill response and cleanup. During the initial department orientation and at whenever a new chemical is introduced thereafter, each employee must be trained to safely work with these chemicals. This training must be documented by the department.

The golden rule for small chemical spills is, "If you spill it, be prepared to clean it up."

Each employee must be trained on:

1. The hazards of each chemical in their workplace (such as flammability or carcinogenicity)
2. Chemical labeling
3. How to protect themselves, personal protective equipment (PPE) required
4. The Material Safety Data Sheet (MSDS) - MSDS are available on the Parkland Intranet and hard copies are kept in the Parkland Police Department and are available 24/7
5. Use of the HAZSOFT MSDS database found on the Parkland Intranet
6. First aid for chemical exposure
7. Spill response and cleanup, location of spill kits
8. Use of the Parkland Chemical Spill Report

For chemical spill response remember CRSC:

1. **C**ontain the spill, assure an appropriate spill kit is used
2. **R**eport the spill, call 911, give details
3. **S**ecure the area, limit exposure, control visitor, patient and staff traffic through the spill area
4. **C**lean up the spill. Remember this is a department responsibility. The Parkland Police are trained to assist with after hour and weekend response, large spills and assistance with Emergency Code Yellow HAZMAT response but should not be expected to cleanup small spills at the unit level. Environmental Services may be requested for a final cleanup of the area once the chemical spill is removed.

The Parkland written Hazardous Material and Waste Management Plan and associated written HAZMAT policies are available on the intranet at http://intranet.pmh.org/Home/PP-Index/eoc.asp. The Hospital Safety Office is available to help with department HAZMAT training upon request by calling ext. 28603 or 28606.

Nursing Informatics

EPIC Grows Every Day

It has been a year since the Big Bang when providers and nurses started documenting in EPIC. In that year Parkland has continued to add documentation to the electronic medical record.

Nursing notes and assessments were added in April. Notes should not be deleted. The correct way to document a change is to use the strike through button and the date/time stamp.

The GI Lab is now in EPIC. Remember that patients going to the GI Lab must be transferred to the GI Lab and their floor bed held just as it is currently being done for the OR.

Critical Values documentation went live April 21. There is a separate Critical Values Results flowsheet which must be filled out any time the lab calls a critical value on a patient. The background on this flowsheet is pink since it is replacing the pink paper sheet from the charts. The flowsheet can be found in the Doc Flowsheet section of the patient's chart.

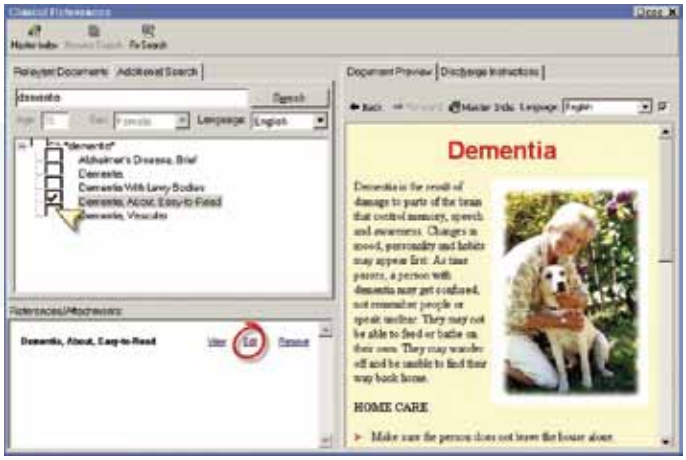
Remember that any questions you have concerning nursing documentation can be directed to your SuperUser or to your Nursing Informatics representative. If you have a question, chances are that other nurses are also having questions. If questions are brought to our attention, they can be answered for everyone.

OPC continues to add clinic documentation to EPIC. Medicine Specialties 7A/B went live March 29. The Epilepsy Outreach and the Cardiac Rehab clinics went live April 27. The Psychology clinic and the Chronic Kidney Disease clinic will go live on May 25.

Patient Education

Increasing Font Size of ExitCare Patient Education Materials

Last month's patient education article went over how to access the ExitCare patient education materials through EPIC, as well as showing how to find desired materials using the index and choosing the language of the material. Sometimes your patient may need the material in a larger font. This month, learn how you can accommodate that need.



Step One
To make the font larger on the text portion of the document, you select which ExitCare material you want by putting a checkmark in the box. The name of the checked material will then show in the section below. Click on "Edit" next to the material's name.

Step Two
Highlight the text of the material.

Step Three
Go to the drop down arrow next to the font size and choose whichever one is appropriate. Click "Accept."

Step Four
This will take you back to your ExitCare screen. Click on "View" in lower left pane and it will open up the document with the changes that you made to the font.

When discontinuing a patient from the Prisma CRRT machine always follow the Prisma screen prompts to ensure safety of the patient and nurse.

Critical Care Vital Signs

Looking Back, Looking Forward

Continuous Renal Replacement (CRRT)

Reminder: When discontinuing a patient from the Prisma CRRT machine always follow the Prisma screen prompts to ensure safety of the patient and nurse. The instructions are as follows:

1. Clamp all lines
2. Press "unload" to unload pumps segments from pump raceways
3. Wait while pumps are unloading
4. Remove pressure pods from housings and lines from tubing guides (Only after pressing unload and pumps are unloaded)
5. Discard set into biohazard bag

Note: removing pressure pods and unloading the pumps before pressing UNLOAD can cause high pressure in the pods, which may result in the pods breaking and risk of blood exposure.

On the Horizon: Soon the CRRT flow sheet will be on EPIC. Also, be on the lookout for education regarding a decrease in the amount of heparin used for the CRRT catheter dwell and special instruction for the CRRT credentialed nurse in the use Cathflow® to declot the CRRT catheter.

Continual Readiness

Multi-Dose Medication Vials: Initial...Date...Good for 28

Multi-dose vials (MDV) are liquid medications that have a sealed top for needle access and contain recognized preservatives such as propylparaben, methylparaben, benzyl alcohol, phenol, thimerisol, benzylalkonium chloride, phenol, cresol, chlorobutanol and mercury-containing compounds.
When using MDVs, the following must be done to be in compliance with Parkland policy and Joint Commission standards:

- Once opened, the MDV must be labeled with the nurse's initials and the date the vial was opened
- If a MDV is dispensed for individual patient use, the vial must be stored with the patient's medications. The nurse's initials and date opened must be written on the vial, not the packaging
- MDVs that contain a recognized preservative are good for 28 days after opening if drug stability permits. Manufacturer instructions/guidelines should always be consulted

The WISH List

Advanced Concepts in Fetal Monitoring Class

On April 6, we had our first Advanced Concepts in Fetal Monitoring Class. This was provided by the Nursing Education department with Jaime Caldwell CNS as the instructor. This class was designed to take the participant from the basics and concentrate on more complicated topics.

One of the many topics that were focused on was Interruption of Oxygen Delivery and Fetal Response to Injury. Clarification on interpretation of cord gases was reviewed as well as the importance of not only looking at the Apgar scores but reviewing the cord gas values on each case. The arterial cord gas represents the fetal-acid base status immediately before birth. This can give the providers a better picture of the overall health of the fetus at delivery. The class also discussed the fetal response to interrupted oxygen delivery. The fetus compensates by distributing cardiac output to the heart, brain and adrenal glands. This results in increased cerebral and myocardial blood flow and peripheral vasoconstriction which maintains BP. This leads to decreased perfusion to peripheral organs. The fetus responds to changes in oxygen and carbon dioxide by stimulating the vagus nerve which causes the fetal heart rate to slow. An example of this is late decelerations.

The class also focused on the changes put out by 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring. This includes a three tiered system (normal, indeterminate and abnormal) for categorization of FHR patterns. This system stresses the evaluation of the fetus at that point in time. It is possible for a fetus to move back and forth between categories.

Many fetal heart rate examples were given and integration of the new Obix sytem was included. The evaluations from the first class were very positive and more classes are scheduled throughout the year. If interested in attending, discuss it with your management team and schedule through Parkland's Virtual Campus (www.phhstraining.org).

The evaluations from the first Fetal Monitoring Class were very positive and more classes are scheduled throughout the year.

Update

Crash Cart Changes

These changes affect the units (Inpatient, Procedure Areas and OPC) that use the cart exchange system and have an airway box on top of the cart. Carts for the Emergency Department did not change.

In the adult and pediatric carts, now only Laryngoscope handles and blades are in the airway box. The protocol for testing the equipment is noted on the box. Labeled "Airway" drawer #4 now contains: ET tubes, stylet, suction catheters, CO2 detector and the remaining airway equipment. All of the airway equipment is still contained in one plastic bag for ease of removal.

The rationale for this change: the airway box was overcrowded which led to difficulty in opening the box. Also added to drawer #4 of the adult cart only: a box (30 count) of prefilled saline syringes.

Please contact your unit educator if you have any questions or comments.

Patient Safety & Risk

Labeling Medication On and Off the Sterile Field:

Improving Patient Safety and Ensuring Joint Commission Compliance

The Joint Commission National Patient Safety Goal (NPSG03.04.01) requires hospitals to: "Label all medications, medication containers (e.g. syringes, medicine cups, basins) or other solutions on and off the sterile field in perioperative and other procedural settings."

Rationale of Goal: This NPSG is a risk reduction activity that is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in any procedural settings such as the OR, Cath Lab or bedside procedures. Errors have resulted when medications and solutions were removed from their original containers and placed into unlabeled containers.

A Loud Wake-Up Call: Unlabeled containers can lead to fatalities. A tragic medication error claimed the life of a Seattle woman. During a surgical procedure the patient was injected with an antiseptic solution, Chlorhexidine, instead of contrast media as indicated. Both solutions were clear and in unlabeled containers. The Institute for Safe Medication Practices (ISMP) reports they have received reports of many similar errors.

How to achieve the goal:

1. Label any medication or solution that is transferred from the original package or container, unless the medication is administered and/or disposed of immediately by the person preparing the medication or solution
2. All labels must contain the following information:
   a. Medication name
   b. Concentration/strength
   c. Dosage
   d. Diluent (if used)
3. Date and time the medication is prepared (not required if the medication is used during the procedure and discarded at the end of the procedure)
4. If you are administering a medication you did not prepare, confirm the information on the label, both verbally and visually, with the person who prepared it
5. Mix and label only one medication at a time
6. Save the original containers until the end of the procedure

For questions, please contact Yvonne Cone, RN, Patient Safety and Risk Project Management Analyst at ext. 20284 or Y1CONE@parknet.pmh.org.

The Magnet designation is the highest level of recognition nursing services can receive.

March to Magnet Designation

Magnet and Shared Governance

The Magnet Recognition Program was developed in 1993 to recognize organizations that demonstrate excellence in nursing practice. Currently there are more than 300 Magnet-designated facilities with an average growth of 32 percent per year.

Magnet recognition goals include:

- Promotion of quality health care services in a professional nursing practice environment
- Identification of excellence in the delivery of nursing services to patients
- Dissemination of best-practices in nursing services

Hospitals that earn Magnet recognition have been proven to have:

- Better patient outcomes
- Lower mortality rates
- Increased patient satisfaction
- Shorter lengths of stay

The Magnet recognition is the highest level of recognition nursing services can receive. Magnet status is granted to hospitals that exhibit exemplary patient outcomes and satisfaction, retain the best staff from all disciplines and have impressive nurse-patient ratios.

Shared Governance

A philosophy and structure that supports:

- Decentralized decision making
- Shared ownership and accountability
- High level of professional autonomy

The Nurse Practice Council (NPC) will serve as Parkland's Shared Governance group. Shared Governance promotes collaboration, shared decision-making and accountability to improve patient outcomes and the work environment.

Nursing Sensitive Indicators (NSIs)

NSIs reflect the structure, process and outcome of nursing care. Patient outcomes that are determined to be nursing sensitive are those that improve if there is a greater quantity or quality of nursing care (such as pressure ulcers, falls and restraints).

Laboratory Scope

Hemolysis

Why is my specimen Hemolyzed?

Hemolysis is one of the most common reasons blood specimens are rejected by the laboratory resulting in re-collection of specimens and increased turnaround times.

What is Hemolysis?

Hemolysis occurs when red blood cells are ruptured, most commonly during blood collection, and hemoglobin and other cell contents are released into the surrounding plasma. Hemolysis greatly impacts the accuracy of many laboratory tests.

How can you prevent Hemolysis?

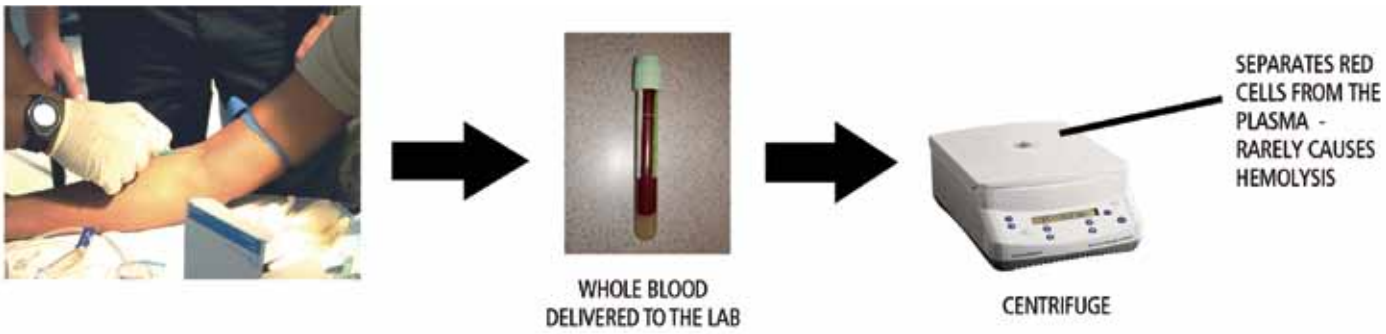
Hemolysis is rarely caused in the laboratory after the specimen is received. A few rare patient conditions can cause red cells to rupture in vivo.

The primary cause of Hemolysis is in these collection techniques:

- Leaving tourniquets on too long (over one minute)
- Using 25 gauge needles or smaller
- Combining a small needle with a large evacuated tube
- Selecting small or fragile veins
- Drawing during IV starts (Hemolyzes specimen 69 percent of the time)
- Pulling back on syringe plungers using excessive force
- Coaxing blood through occlude needles
- Excessively milking or squeezing capillary sites
- Forcibly filling evacuated tubes with a syringe

Hemolysis results in recollection of specimens and increased turnaround times.

How does the lab detect Hemolysis?



Leadership Lingo

Strengthening Nursing's Influence on Health Care Reform

Are nurses viewed by others as having a strong influence on health care policy and health care reform? If you said yes, you may be in for a surprise. A recent 2009 Gallup poll surveyed U.S. opinion leaders about their views of nursing and nursing leadership. Many of the opinion leaders directly involved in health care reform felt that the opportunities to learn from nurses and implement their ideas is being squandered.

Nurses are continuously perceived as honest and ethical; ranked second as a trusted source of health care knowledge right behind physicians. However, polls reflected nurses as having minimal influence in health care reform. Most wanted to see nurses have more influence, such as reducing medical errors, improving quality of care and promoting wellness.

Barriers preventing nurses from contributing to improvements in planning, policy development and managing health systems were essentially structural issues. Most believed nursing, as a profession, lacks a single voice on national issues, having no strategic vision, different levels of education to become a nurse, etc. Many perceived nurses as non-important decision makers at a time when health care reform is occurring. An effective structure is needed to increase alignment, representation and power as a group, placing nursing at a level equal to influential groups like the American Medical Association (AMA).

The opinion leaders offered two suggestions: Nurses were perceived by the opinion leaders as having a lack of interest in being heard; therefore, become more unified as one voice, focusing on key issues in health policies. Secondly, society's expectations of what nurses can achieve needs to be higher. Nurses need to be accountable not only for quality patient care, but also for quality health care leadership. One action every nurse can do today is to join and participate in a professional organization which represents the nursing profession.

References:

Texas Nursing, Winter 2010, Vol.84, No.1

Parkland

Clinical Care Connection is edited by the Leadership and Organizational Development Department at Parkland Health & Hospital System. All issues of *Clinical Care Connection* can be found on the intranet under the Nursing Education tab. Please send all inquiries to clmill@parknet.pmh.org.