

# Clinical Care Connection



Parkland

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

## What is New in Infection Prevention?

*Infection Prevention (IP) staff would like to share some of the IP-specific projects they are currently working on hospital-wide. For department/unit specific results, please contact your director.*



Handwashing and "scrubbing the hub" of central lines are two of the simplest ways to reduce health care associated infections.

### PATIENT ROOM CLEANING PROJECT

Cleaning and disinfecting environmental surfaces is fundamental to reducing health care associated pathogens. Although contaminated surfaces can serve as reservoirs of potential pathogens, the transfer of microbes from environmental surfaces to patients and staff is largely via hand contact. In addition to the disinfectants used for environmental surface cleaning, the physical removal of microorganisms and soil is achieved by wiping or scrubbing the surfaces.

This project was developed to determine the cleaning of high touch items in the patient room when the patient is discharged.

- After the patient leaves the room (discharge), but prior to Environmental Services (EVS) cleaning the room, the nursing manager/designee or EVS supervisor will mark the high touch items in the room with Glo Germ fluorescent powder
- When EVS is finished cleaning the room, the individual will go back and shine a UV light on the marked items. If the fluorescent powder was not completely removed it will glow beneath the UV light, indicating a fail result
- Currently both EVS and the nursing units do the monitoring, with a transition to nursing units doing the majority of the audits
- The results are then placed in the SharePoint site in a similar fashion as the hand hygiene observations

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## Patient Safety and Risk

### APOWW

You get a call from the emergency room telling you that you will be receiving a new admission and the patient is "APOWW'D" and will require 1:1 observation. What exactly does that mean and what do you have to do?

APOWW stands for Apprehension by Peace Officer Without Warrant. This allows a peace officer to detain and transport the person to a facility for psychiatric evaluation. This is usually done when a family member is concerned that the patient is a risk to themselves or others and calls the police for assistance. The APOWW status lasts up to 48 hours or until a psychiatric evaluation determines the patient is no longer a risk to themselves or others.

The patient is brought to the Psych ER for evaluation. However, these patients often have a medical component that also needs to be addressed and the patient may be transferred to the Main ER for medical evaluation and may be admitted to a med/surg floor for further observation. Once the patient leaves the secured psychiatric area the patient must be maintained under constant observation. This is because they are still considered at risk for hurting themselves or someone else.

As a health care provider, once the patient arrives at our hospital, we take on the responsibility of the APOWW. If anything happens to the patient while under the APOWW (the patient elopes, the patient harms themselves or someone else) we are responsible and the event MUST be reported to the State.

The Parkland Police Department can be contacted for assistance with APOWW patients or to answer questions. If a patient under APOWW status should happen to leave Parkland without permission contact the Parkland Police immediately. They will need to conduct a search of the premises and find the patient immediately.

#### Must Do's for APOWW patients:

- Recognize that the need for APOWW is because of a concern that the patient may hurt themselves
- Identify resources needed for constant observation
- Ensure all ward staff are aware of patient's APOWW and constant observation status
- Notify Parkland Police immediately for any elopement of an APOWW patient

*Some patients with intravenous catheters placed in their major veins may develop infections with bacteria and fungal organisms. A large proportion of these infections are prevented by inserting the catheters under sterile conditions, maintaining and accessing the catheters in a clean and safe manner and removing the catheters as soon as they are no longer needed.*

*(continued from page 1)*

#### CENTRAL LINE INFECTION PREVENTION (CLIP) PROJECT

Some patients with intravenous catheters placed in their major veins may develop infections with bacteria and fungal organisms. These are called central line infections. Occasionally, central line infections can lead to preventable deaths among patients. A large proportion of these infections are prevented by inserting the catheters under sterile conditions, maintaining and accessing the catheters in a clean and safe manner and removing the catheters as soon as they are no longer needed. Parkland has implemented a series of evidence-based practices to prevent these infections.

- Emphasis includes cleansing of the central line hub ("Scrub the Hub") for 15 seconds with an alcohol or chlorhexidine pad prior to access. This should also be performed for peripheral IV lines
- Designated assistant documents during the insertion, adherence with prevention measures on the central line checklist
- Reports are sent daily to the nursing units to indicate whether there are any infections

#### HAND HYGIENE

This is considered the most important intervention to stop the spread of harmful microbes in health care settings. Alcohol gel or foam containing >60 percent alcohol effectively kills most bacteria and viruses. But alcohol is ineffective against some microbes causing diarrhea such as Clostridium difficile and Norovirus. Traditional hand washing with soap and water is required for these conditions. Hand hygiene is a worldwide initiative, with most published literature reporting hand hygiene adherence rates of 40-70 percent.

- To date, over 300 "Infection Prevention Champions" representing all the clinical units of Parkland were trained to perform direct observation of hand hygiene practices. In addition, 160 staff members were trained to enter data into a hand hygiene database on the SharePoint site
- Corporate Communications developed messaging themes regarding hand hygiene
- Hand hygiene observations per month have increased from about 125 to 1,200

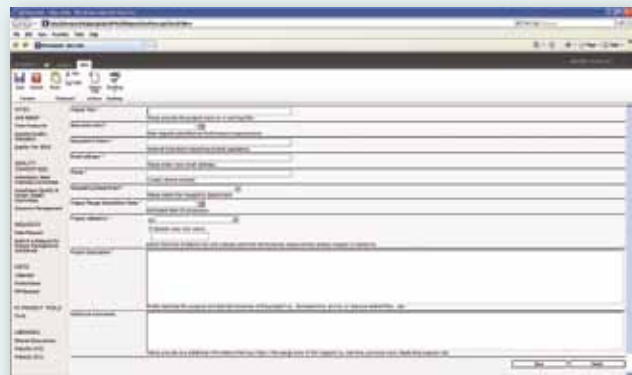
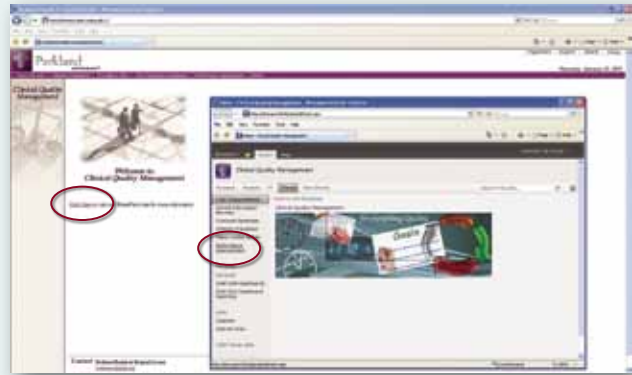
Look for part two of this article in the April issue of *Clinical Care Connection*.

## Performance Improvement

### Request Instructions

Does your department need assistance from the Performance Improvement department with project management? A simplified process has been created to help you make the request. The request form can be found on the Performance Improvement department SharePoint site. See instructions on how to access the site below:

- Access the Parkland Intranet and click on the department drop down menu located on the right side of the page
- Select "Clinical Quality Management"
- Click on the "click here" button and select Performance Improvement
- Click on "Submit a Request for Project Management Assistance" located on the left side of the screen
- Complete the list of questions on the Project Management Request page



If you have questions please contact Karen Collins at ext. 20417.

*By Jan. 1, 2012, the availability of pulse oximeters will be expected in every delivery room and highly recommended for use whenever supplemental oxygen, positive pressure ventilation or continuous positive airway pressure are considered necessary.*



#### *The WISH List*

### **Changes in the Neonatal Resuscitation Program**

*The following are a few highlights of the upcoming changes for the Neonatal Resuscitation Program (NRP):*

#### **USE OF PULSE OXIMETRY**

This may be considered one of the biggest changes in the *NRP sixth edition*. By Jan. 1, 2012, the availability of pulse oximeters will be expected in every delivery room and highly recommended for use whenever supplemental oxygen, positive pressure ventilation (PPV) or continuous positive airway pressure are considered necessary.

#### **USE OF A MANOMETER**

By Jan. 1, 2012, all self-inflating bag and masks will be required to have a manometer to monitor PPV and oxygenation levels to help ensure adequate ventilation.

#### **NRP ALGORITHM**

The *NRP sixth edition* algorithm has been simplified and emphasizes the importance of PPV using a pulse oximeter. The algorithm also places a greater focus on assuring adequate PPV before starting chest compressions.

#### **MRSOPA GRID**

A mnemonic grid was developed to help aid in remembering the six steps for improving efficacy of PPV. This acronym represents:

- M** – Adjust mask to assure good seal on the face
- R** – Reposition airway by adjusting head to “sniffing” position
- S** – Suction mouth and nose of secretions, if present
- O** – Open mouth slightly and move jaw forward
- P** – Increase pressure to achieve chest rise
- A** – Consider airway alternative (endotracheal intubation or laryngeal mask airway)

**Please note:** *NRP sixth edition* materials will be released in Spring 2011

## Continual Readiness

### Improving Patient-Centered Care

At Parkland and all hospitals, we exist for the patient. Patient-centered care has become the focus of a national effort to ensure that the unique needs of all patients are being met along their continuum of care.

Caring for our patients in a way that they understand involves efforts to excel at communication and cultural competence. Each patient with their unique clinical, social and educational situations has a right to understand and to be understood. The Joint Commission is helping hospitals to achieve this by providing a guide, titled "Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals."

Patient- and family-centered care can only be achieved by a staff that communicates effectively and is culturally aware. The rewards for this are high not only for the patient, but for the effect our positive interactions will have on each patient's quality, safe and equitable care.

In the following months, Continual Readiness efforts will be focusing on the guidelines provided by The Joint Commission to determine Parkland's readiness in the areas of leadership; data collection and use; workforce; provision of care, treatment and services and patient, family and community engagement. Additionally, we will be assessing processes and work aids in the areas of admission, assessment, treatment, discharge and transfer and end-of-life care to enhance our ability to meet the standards and to enable providers to meet our patients' unique clinical, demographic and personal characteristics in a holistic approach to their care.



Jennifer Browning, RN II, Radiology

#### Reference

The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.

### Care Management Corner

#### The Role of Case Managers and Social Workers



Valsamma Abraham,  
case manager

The Care Management department is comprised primarily of RN case managers and licensed master's-prepared social workers. We care for hospital-based inpatients, outpatients (observation and short stay patients), and ESD patients. We also see outpatients in the specialty clinics and "walk-in" clients who need assistance.

The case managers perform an initial clinical review for medical necessity on all new admissions using the Milliman CareWebQI software. The case managers follow complex discharge patients based on information obtained from their own assessments and information obtained from the multidisciplinary care team.

The social workers see patients upon referral. These referrals may originate from the patient, the family, the physician, the nurse or from just about anyone. Social workers also learn which patients need their services based on information obtained during rounding with the care team. A goal for 2011 is to automate the SW referral process via EPIC.

Both case managers and social workers present those patients who are deemed "length of stay" outliers at a weekly meeting designed to find solutions for safe discharge on very complex patients, many without insurance or a financial source who therefore have very limited discharge options.

**If you would like an in-service for your staff on this topic or have a question, please call ext. 28164.**

## Patient Education Update

### Accessing ExitCare materials through EPIC in WISH Areas

ExitCare is the patient education program available through EPIC. Since the December 2010 EPIC update, the process for accessing ExitCare patient education materials in EPIC has changed. Here's how you get to the ExitCare materials:

On the 'Activities' page on the left side of your screen, choose "Clinical References." Click on "Clinical References." If you do not see "Clinical References," click on "More Activities" and you should see it there.

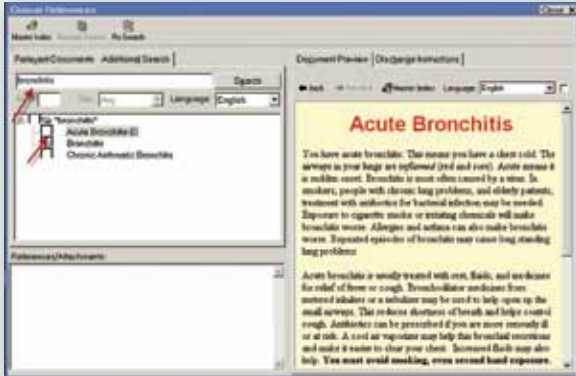


This will open up a box offering you health topics. You can choose one of these and, if appropriate, print it to give to the patient. Any problems or diagnoses entered on the patient's chart will show on the left of the screen under the "Relevant Documents" tab.

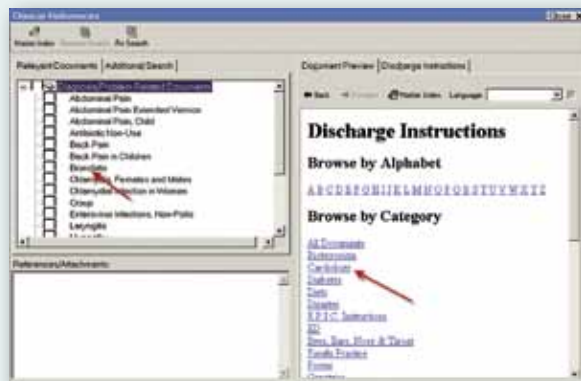
You can also select some of the material in several languages. You can select the drop-down next to the Language box to see which languages are available. At Parkland, you should be able to access English, Spanish, Vietnamese, Portuguese and Russian. A given material may not be available in all these languages, though most are available in Spanish. Other languages are not available at this time.



The "Easy-to-Read" materials (materials sent to ExitCare by Parkland) will be listed as such in the index (see picture below). The reading level of these materials is lower than the ExitCare-created ones. These materials are accessed in the same way as the previously available materials and can be identified easily because they have "Easy-to-Read" by the title.



Or you can browse the index (by alphabet or category) and choose a topic from there.



Again, you can browse the index (by alphabet or category) and choose a topic from there.



Pharmacy Forum  
**Pharmacy Formulary**

<b>23.4 percent Sodium Chloride</b>	Amendment to the Criteria: 23.4 percent sodium chloride will have a double check prior to administration (checked by nurse, double checked by provider). In addition, MAR documentation by the nurse is required. The nurse will choose "given by other" and document which provider double checked and administered the medication in the comment section of the MAR.
<b>Ezetimibe (Zetia®)</b>	Restriction will remain the same: Restricted to attending faculty in the lipid clinic
<b>Statins in Combination with Gemfibrozil</b>	Caution: Review dose limitations when using Gemfibrozil in combination with statin therapy. The statin should not exceed 10mg/day when used in combination with Gemfibrozil.
<b>Hydrocodone/APAP 10/650; 5/500 and Oxycodone/APAP 5/500</b>	Formulary Deletion: Due to Drug Safety Concern by the FDA
<b>Oxycodone/APAP (Percocet®) 5/325</b>	Formulary Addition
<b>Molindone (Moban®)</b>	Formulary Deletion: No longer manufactured

The online Parkland Drug Formulary can be found at <http://www.crlonline.com>. The target date for implementation is March 15.

*March to Magnet*  
**Nursing Quality Indicators**

Members of the Magnet Designation department recently had the opportunity to attend the National Database for Nursing Quality Indicators (NDNQI) conference in Miami. The mission of NDNQI is to promote safety and quality improvement efforts by providing research-based national comparative data on nursing care and the relationship to patient outcomes (NDNQI, 2010). Here are a few topics discussed:

**NURSING SENSITIVE INDICATORS (NSIS)**

Part of our Magnet journey includes collecting two years of unit-based data on 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, restraints, urinary tract infections and pediatric IV infiltrations). Currently the Magnet department is matching our units to the NDNQI unit descriptions. This will allow us to benchmark Parkland nursing units against similar units nationally.

**MEANINGFUL USE**

The American Recovery and Reinvestment Act of 2009 provided for incentive payments for the meaningful use of certified Electronic Health Record technology. These incentives are to promote providers and institutions to move to electronic record keeping, and to initiate an electronic record which can be used to promote safety and quality. The use of EHR assists in maintenance of complete and accurate information so that we know more about our patients, leads to better access to information so that better decisions can be made, enhances patient empowerment, increases safety and reduces costs.

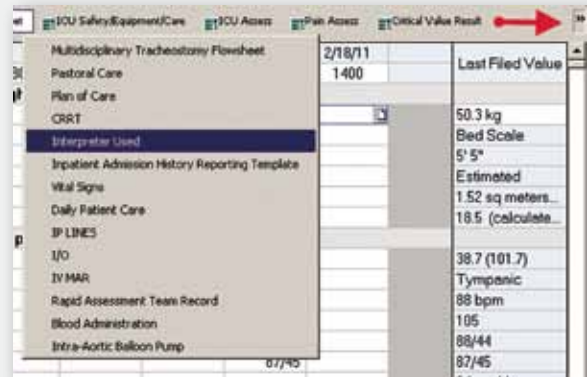


*The use of EHR assists in maintenance of complete and accurate information so that we know more about our patients, leads to better access to information so that better decisions can be made, enhances patient empowerment, increases safety and reduces costs.*

## Using Flowsheets Correctly

There have occasionally been incidents of nurses double documenting the volume of blood their patient has received. The correct procedure is to document the blood volume in the volume row of the Blood Administration flowsheet. It should not be documented in the IV MAR flowsheet or the ICU flowsheet. Also, it is important to use the Blood Administration flowsheet to document that the transfusion has been completed.

There is also a new flowsheet available to ICU nurses when they require interpreters. It is located in the ICU doc flowsheet. Use the arrows on the right hand side of the flowsheet to select "Interpreter Used." It will bring up the correct flowsheet.



*An increasing number of studies are showing that obesity begins in childhood, but obesity and its associated health issues can be avoided through healthy lifestyle choices. Interventions need to begin early.*

### Outpatient Observations Obesity in Texas

Obesity has become a national epidemic and an area of growing concern at the state level. In 2005, there were nearly 3 million more obese adults in Texas than in 1990. Only 12.3 percent of Texas adults were obese in 1990; by 2005, that share had more than doubled to 27 percent. The numbers are well above the national average of 24.4 percent (Texas Comptroller of Public Accounts [TCPA], 2007).

Obesity increases the risk of costly chronic illness such as heart disease, stroke, cancer and diabetes – all are among the leading causes of mortality in the U.S. In addition, obesity is believed to have worse physical health related quality of life than smoking or problem drinking (Sturm & Wells, 2001). Estimates of the number of years of life lost as a result of obesity range as high as 20 years for certain age and racial/ethnic groups (U.S. Department of Health and Human Services [USDHHS], 2003).

The TCPA estimates that costs to Texas businesses due to adult obesity and obesity related illnesses totaled more than \$3.3 billion in 2005 (TCPA, 2007). The costs are derived from lost productivity and increased health and disability insurance. Studies have shown that obese employees take more sick leave than non-obese employees and are twice as likely to have high level of absenteeism (USDHHS, 2003). If the current trend continues unchecked, by the year 2025, it is estimated that 48.6 percent of Texas adults will be obese and only 14.4 percent will be of normal weight. It is projected that health care costs will comprise more than 55 percent of the state budget (TCPA, 2007).

An increasing number of studies are showing that obesity begins in childhood. In a Texas study conducted from 2004-2005, researchers found that 42 percent of fourth graders were overweight or at risk for obesity, as were 39 percent of eighth graders and 36 percent of eleventh graders (TCPA, 2007). Obesity and its associated health issues can be avoided through healthy lifestyle choices. Interventions need to begin early with our pediatric population. By promoting healthy lifestyles, we can improve the quality of life for all Texans, and significantly reduce morbidity and health care costs.

#### References:

Sturm, R., & Wells, K.B. (2001). Does obesity contribute as much to morbidity as poverty or smoking? *Public Health*, 115:229-236.

Texas Comptroller of Public Accounts. (2007). The cost of obesity: Squeezing Texas employers. Retrieved from <http://www.window.state.tx.us/.../obesitycost/96-1241245costscalories.pdf>

U.S. Department of Health and Human Services.(2003). Prevention makes common "cents." Retrieved from <http://aspe.hhs.gov/health/prevention/prevention.pdf>

## UAP Exclusive

### Managing Angry Patients, Family or Visitors

According to the National Institute of Safety and Health, 45 percent of the perpetrators of workplace violence are patients, patient family members or visitors. Client behaviors impact staff behaviors and, in turn, staff behaviors impact client behaviors. With this in mind, it is important that we realize and understand that in every encounter with an angry individual the path to a peaceful conclusion begins before we have ever said a word.

#### NON-VERBAL PHASE

Non-verbal preparation is completed in the first few seconds of the encounter but must be maintained throughout.

**Personal Space:** Every individual possesses a sense of personal space, a room of sorts, inside which we feel most comfortable and safe. This personal space varies depending on who may be approaching and for what reason and the context of the situation. Things such as gender, size and cultural background may affect the amount of personal space an individual requires. A good general rule to follow is to allow a personal space of three feet. But remember, this space should also afford you a sense of comfort and safety. By maintaining an individual's personal space, we become less threatening on approach and take the first step toward a peaceful resolution.

**Body Language:** A picture paints a thousand words. What story are you telling? Body language includes facial expressions, gestures, posture, movements and pace. Body language can serve to escalate or de-escalate a given situation. A gentle look of concern works better than an angry scowl. Quiet hands send a message of peace that gesturing hands cannot. Maintain a passive posture. Reduce your movements to only those necessary in the situation.

**Supportive Stance:** A supportive stance is one outside the individual's personal space, standing at an angle, with your body slightly turned instead of face-on to the client. This stance communicates respect by acknowledging the patient's personal space, is non-threatening and non-judgmental and provides you with an escape route should the patient become violent.

#### PARAVERBAL COMMUNICATION

This is the vocal part of speech, excluding the actual words that we use. How we say what we say. It is the tone, inflection and volume of our voices. The words we choose to stress.

**Tone:** Avoid inflections of impatience, frustration, condescension, anger, inattention, etc.

**Volume:** Keep the volume appropriate for the distance and situation. Speaking softly and calmly is more effective than yelling.

**Cadence:** Deliver your message using an even rate and rhythm. Guard against rushing your message and thereby having it misunderstood.

**Stress:** By stressing certain words in our message, we completely change the message we are sending. Asking, "You are *angry* because you did not get any sausage with your breakfast?" is an entirely different message than, "You are angry because you did not get any *sausage* with your breakfast?" By stressing the word angry we become judgmental, questioning the patient's emotional maturity. Take care when and why you stress certain words.

Throughout these encounters with angry individuals we are seeking a rapport. To develop rapport, we must demonstrate empathy and understanding. To show empathy is to identify with another's feelings. It is to emotionally put yourself in the place of another. By doing so we can reach our goal of mutual trust and respect, fostering an environment in which the patient feels safe and understood.

*Client behaviors impact staff behaviors and, in turn, staff behaviors impact client behaviors. With this in mind, it is important that we realize and understand that in every encounter with an angry individual the path to a peaceful conclusion begins before we have ever said a word.*



*For years advanced specialties such as critical-care, neurology and oncology have overshadowed medical-surgical nursing as a specialty. Well, that's not the case anymore. In 1991 the development of the Academy of Medical-Surgical Nurses (AMSN) ignited the drive to recognize medical/surgical nursing as a specialty.*



### *Med-Surg Memos*

## **Steps toward Obtaining Your Medical-Surgical Certification**

Medical-Surgical Nursing has been identified as the foundation of many nursing specialties. A vast majority of nurses began their careers by mastering essential nursing skills as staff nurses for medical-surgical units prior to aspiring to more advanced specialties. For years advanced specialties such as critical-care, neurology and oncology have overshadowed medical-surgical nursing as a specialty. Well, that's not the case anymore. In 1991 the development of the Academy of Medical-Surgical Nurses (AMSN) ignited the drive to recognize medical/surgical nursing as a specialty.

There are three certification exams in medical-surgical nursing are offered by two different organizations:

**The Medical-Surgical Nursing Certification Board (MSNCB)**, a partner organization with the AMSN, is the credentialing board for Certified Medical-Surgical Registered Nurses (CMSRN) certification. Any RN who passes the exam becomes a CMSRN. The CMSRN credential identifies a nurse as one who specializes in medical-surgical nursing. It's available to anyone who has a BSN, an associate degree (AD) or a nursing diploma.

**The American Nurses Credentialing Center (ANCC)** is a subsidiary of the American Nurses Association (ANA) and is the credentialing board for the ANA. The ANCC currently offers exams for medical-surgical nurses. You can be board certified (BC) if you're an RN with a bachelor's degree. You can be certified (C) if you're an RN with an AD or diploma in nursing. The credentials BC and C are also used for other specialty designations through the ANCC, such as geriatrics and vascular nursing.

Perhaps you are considering obtaining a certification in medical-surgical nursing. MSNCB has identified the top five reasons why you should:

- Validate your advanced clinical knowledge in medical-surgical nursing
- Feel a sense of pride and professional accomplishment
- Increase your earning power and job satisfaction
- Be rewarded with peer and collegial respect
- Help protect the public by promoting expert patient care

### **Steps toward getting certified:**

- Select the organization you would like to obtain certification (CMSRN or ANCC)
- Visit the organizational website of your choice to determine your eligibility and other criteria for testing at [www.medsurgnurse.org](http://www.medsurgnurse.org) or [www.nursingcredentialing.org](http://www.nursingcredentialing.org)
- Register to take the exam and pay the fees
- Utilize resources for the organizational website and other resource to prepare for your exam
- Pass your exam and obtain credentials for medical-surgical certification

## Critical Care Vital Signs

### The New CRRT Machine: Prismaflex by Gambro

Acute renal failure (ARF) is a sudden decrease in kidney function that is characterized by a sudden decrease of the glomerular filtration rate and consequently an increase in blood nitrogen products (blood urea and creatinine). Some of the common causes of ARF that present to the ICU are those patients whose presentation may be sepsis, hemodynamic instability, myoglobin in the urine or nephrotoxins. ARF can be treated with intermittent hemodialysis (IHD) or continuous replacement renal therapy (CRRT); however, because hemodynamic instability is associated with IHD, CRRT is the prefer choice for ARF treatment. CRRT has been in use for numerous years at Parkland by the use of Gambro's Prisma CRRT machine. Now, Parkland has upgraded to Gambro's Prismaflex as the CRRT machine of choice used in the ICU.

#### WHAT'S NEW WITH THE PRISMAFLEX?

**Pre Blood Pump:** used for Citrate or Pre-replacement fluid

**Return Pressure Line & Deaeration Chamber:** Efficiently collects and removes air microbubbles

**Bar Code Reader:** recognizes type of hemofilter to be used

**Pinch Valves:** allows all hemofilter sets to redirect the flow of Dialysate and replacement pumps

**No Prime Collection Bag:** priming fluid collects in affluent collection bag

#### WHAT MODES OF TREATMENT AVAILABLE WITH PRISMAFLEX?

**SCUF:** slow continuous ultrafiltration is intended to remove excess fluid

**CVVH:** continuous veno-venous hemofiltration strives to provide convective clearance of excess waste products; middle/large molecules; balance of electrolytes, acid/base and excess fluid

**CVVHD:** continuous veno-venous hemodialysis can deliver diffusive clearance of excess waste products; small molecules; balance of electrolytes, acid/base and excess fluid

**CVVHDF:** continuous veno-venous hemodiafiltration aims to provide diffusive clearance of excess waste products; small molecules; removal of middle/large molecules; balance of electrolytes, acid/base and excess fluid

**Hemoadsorption:** an extracorporeal blood purification technique that provides removal of target substances from the blood by adsorption of the target substances to a sorbent cartridge/filter

#### WHAT PRINCIPLES OF DIALYSIS USED WITH THE PRISMAFLEX?

**Ultrafiltration:** movement of fluid through a semi-permeable membrane by a pressure gradient

**Goal:** fluid removal

**Prisma solution used:** none

**Diffusion:** movement of solutes from an area of high concentration to an area of lower concentration

**Goal:** removal small molecules such as creatinine/blood urea; corrects electrolytes and acid/base imbalances

**Prisma solution used:** Dialysate Fluid

**Convection:** movement of solutes with water flow or "solvent drag" where the more fluid moved through a semi-permeable membrane leads to increase removal of solutes

**Goal:** removal of small, medium and large molecules

**Prisma solution used:** Replacement Fluid

**Adsorption:** molecular adherence to the surface or interior of a semi-permeable membrane

**Goal:** hemofilter membrane may have properties that target proteins that may have adsorption affects



Parkland now uses the Gambro Prismaflex for continuous renal replacement therapy (CRRT).

## ATTEND OUR UPCOMING EVENTS

Make sure to register for the next installment of the Plastics Series, "Skin Malignancies and Moh's Repair." It will be held 7:15-45 a.m, Wednesday, April 13 in the MacGregor W. Day Auditorium. This event is presented by James Thornton, MD, associate professor of Plastic Surgery at UT Southwestern Medical Center.

Another upcoming event is "Psychiatric Nursing Grand Rounds: Suicide." This will be from 12-1 p.m., Wednesday, April 27 in the MacGregor W. Day Auditorium.

To register for either of these events, go to [www.trainingatparkland.org](http://www.trainingatparkland.org). Parkland Health & Hospital System, Department of Nursing Education is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

## SAVE THE DATE FOR THE 2011 QUALITY FAIR

The seventh annual Quality Fair will be held from 6 a.m.-4 p.m. Wednesday, Sept. 14 in the MacGregor W. Day Auditorium. The entry deadline for projects is June 24. The Intranet page and entry forms will be available soon. For more information please call ext. 28373.

## PATIENT SAFETY WEEK

Patient Safety Awareness Week will be March 7-11. Look for more information about learning opportunities soon from Patient Safety & Risk.

## Clinical Staff Services

### IV Pump Conversion Update

Thank you for your assistance in making this conversion a success. Within seven hours, over 2,500 pieces of equipment were deployed hospital wide.

#### Just a few reminders:

- With PCA use, after the initial setup, you may make changes to the program and bolus with a code. The key is only required with the initial programming
- Be sure to add the SpO2 module when using the PCA function. This will assist in detecting if the patients respiratory status becomes compromised while receiving narcotics. A "Good Catch" was reported on day one of implementation by utilizing this feature
- When administering IVPB medications, remember to use the blue hook in the secondary tubing set to lower the primary fluid. The IVPB must be at a higher level than the primary fluid.
- The pump level on the pole should be at the level of the patients chest
- Use the "control a flow" tubing with IV TKO rates and IV fluids at a controlled rate with no additives, if the patient's condition allows. This will maximize the use of the IV pumps for your unit
- Some antibiotics may be administered per "control a flow" or gravity. For a complete listing, please refer to the Parkland Intranet, "Pharmacy Department," "Provider Information," then "Adult IV Guidelines." The link is [http://intranet.pmh.org/pharmacy/Forms/adult\\_IV\\_guidelines.pdf](http://intranet.pmh.org/pharmacy/Forms/adult_IV_guidelines.pdf)
- Guardrail library updates will be sent out periodically. These updates will be communicated via the Postmaster e-mail. You may verify the new library (data set) is pending by going to "options" — "page down" to the third screen — select "data set status"— verify if "pending." To receive the update for your pump, you will need to recycle the power and select new patient. Your pump will then receive the update. If your patient condition is unstable, you may delay this process

**If you have further questions, please do not fail to ask. It is an ongoing learning process. You are embracing change like champions.**

## Laboratory Scope

### Complete Blood Count with Differential Results

A complete blood count with differential (CBC w/Diff) is analyzed on the automated Hematology line, which performs five part differentials. If the results of the cell count and the five part differential do not contain pre-defined review flags the results are released.

A CBC w/ Diff that does not require a manual smear review (scan) is reported with absolute differential results and no RBC Morphology grading. If review flags are present that pertain to either the WBC Differential or Differential Morphology, results will be held until a manual smear review or follow up testing is performed. Results not associated with the review flags will be released. A CBC w/Diff that has gone through the smear review process (without the performance of a manual differential) can be recognized by its absolute differential results and the presence of RBC morphology grading.

A manual differential will be ordered by the technologist when certain criteria, such as presence of blasts or NRBCs, are met during the smear review. The manual differential will include RBC morphology grading but is uniquely recognized by the differential counts reported in percentages.

A CBC w/Diff that has a manual differential will include the presence of RBC morphology grading and differential results reported in percentages (rather than absolute counts). A Pathology referral will be ordered if certain criteria are met. Smears will be referred for a number of different reasons, including (but not limited to) the presence of malignant cells, moderate or marked schistocytes, or microorganisms. A Pathology referred CBC w/Diff may include an automated differential, a scanned review or a manual differential. In most cases, a referral is reported within 48 hours and results communicated to the clinician as needed.

There are times when Lab Central receives a downtime requisition with a hand written order for a peripheral smear. Please note that the "peripheral smear" is not a valid order and therefore cannot be processed. If the provider wants a differential performed, the EPIC order should be a CBC w/ Diff. Peripheral blood smear slides are made and reviewed when indicated by the approved reflex criteria.