

# Clinical Care Connection

Connecting Parkland's clinical staff with the latest information and patient care updates February 2009

## Our Goal is Zero Falls

In July 2007 Parkland implemented a Fall Protocol in an effort to eliminate patient falls. The protocol as outlined in NSG 25-09 includes three primary purposes:

**Educate patients and families about fall risk** – “Tips to Keep You from Falling” located inside the Patient Information Packet and other unit-specific teaching plans should be used when teaching patients and families about the risk of falls on admission to the unit. This education should be documented on the Interdisciplinary Discharge Planning and Education Record.

**Identify those patients who are at risk of falling** – The RN should assess the patient's fall risk, using the Morse Fall Scale on admission and each shift. The total points from the Morse Fall Scale will be documented in the “Fall Risk” section of the Patient Observation and Flow Sheet.

**Institute measures to prevent or reduce falls** – Fall Protocol should be initiated when the patient has a risk score of 51 or greater. The interventions include:

- Documentation on the Plan of Care Needs & Referral List
- Placing a green fall precautions armband on the patient
- Placing a fall precautions sign at the head of bed or outside the door
- Placing a green sticker on the front of the chart

*(“Zero Falls” continued page 2)*



While the patient is on fall protocol, hourly rounds will be documented on the Daily Patient Care Record/Flow Sheet.

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Patient Education Update

## *UAP Corner*

**This month's Continuing Education Program will be at 7:30 a.m, 10 a.m. and 1:30 p.m. on Monday, Feb. 2 in Room SR-2 (in the basement of Support Services Building B). The one-hour presentation will cover rubella. Patient Care Assistants, Health Unit Coordinators, Medical Assistants, Certified Surgical Assistants, Techs and all others interested are encouraged to attend. Please log on to [www.phhstraining.org](http://www.phhstraining.org) to reserve your seat.**

## *Nurse Practice Council*

**Hello Parkland, just a note from the Nurse Practice Council (NPC). We represent the nursing staff at large with representation from all areas of Parkland. The council functions to provide staff nurse input into nursing practice issues and to communicate related activities and decisions to the nursing staff at large. On Feb. 12, we will be conducting another PUPS survey ... see you soon!**

## **Zero Falls** *(continued from page 1)*

While the patient is on fall protocol, hourly rounds will be documented on the Daily Patient Care Record/ Flow Sheet. The hourly rounds will include confirmation of the following:

- Bed in low position
- Call light/bell within reach
- Personal effects within reach
- Toileting offered if awake and allowed
- Fluids offered if aware and allowed
- Side rails are elevated as appropriate

The RN will reassess the patient each shift to determine the need to remain on fall protocol. The fall protocol will be discontinued when the patient's risk for fall score is less than 51 for more than 24 hours.

Some specialty areas did not implement the fall protocol as outlined in NSG 25-09, so please take this opportunity to review your unit specific procedure. Falls continue to occur in our system, we had 110 falls in the fourth quarter of FY08. This tells us that there is a disconnect between the process and the outcome, so it is essential that a PSN report be completed on every fall. In addition, we are requesting that managers complete a fall interview tool for each fall level "C" and above. The fall committee is reviewing this data to identify trends or root causes that can help us determine process changes that might help us improve our outcomes. If you have questions, you can contact your representative on the fall committee, a patient safety analyst or your nurse educator.

### *Critical Care Vital Signs*

#### **Prepping your Patient for Colonoscopy**

There is no easy way to prep for colonoscopy, but there are things you can do for your patient to make it less uncomfortable.

- Make sure there is plenty of toilet paper in the patient's restroom.
- Have the patient drink plenty of fluids the day before the test to prevent dehydration.
- Ensure a clear path to the restroom.
- Provide some soft wipes for cleaning up.
- The gastroenterologists write prep orders to meet the needs of the specific patients. All orders will have clear liquids and a gallon of Golytely the day before the procedure. Orders can also include:
  - Extra days of a clear liquid diet
  - Medications to soften stool
  - Specific times to start orders

Golytely should be started early in the evening the night before colonoscopy. Patients should be instructed to drink an 8 oz glass of Golytely every 10 minutes, until it is gone (about two hours). Golytely works best this way, and the better the prep, the more the doctor can see during the exam. Golytely tastes like salt water, but it goes down easier if it's cold and sipped through a straw. Mild abdominal cramping, feeling full and some chills are normal. After finishing their Golytely the patient should be NPO EXCEPT MEDS. All medications, except for diabetic medications, should be given as ordered with a small sip of water.

Don't hesitate to call the GI Lab at ext. 28839 with any questions.

## Laboratory Scope

### HIV Antibody Testing Moves into the 21st Century

Pathology's Immunology Laboratory has recently added Ortho Clinical Diagnostic's HIV 1 and 2 Antibody test to the Vitros ECI analyzers. This test was FDA approved in April 2008 and is a major leap forward in technology, work flow and customer service. Ortho's assay is a chemiluminescence-based test for detecting both HIV 1 and 2 antibodies in a patient's serum. Compared to the previous instrumentation, it is just as sensitive but more specific for HIV, thereby reducing the rate of false-positive tests that need costly confirmatory testing. From a work flow standpoint, the Vitros analyzers also run all the routine hepatitis and rubella tests, so there is now one common platform for maintenance and employee training.

As a true random access test, the new assay allows for continual addition of samples with an analytic turnaround time of just 48 minutes compared to the "batch-mode" of the previous analyzer that took over three hours to complete (not to mention that if anything went wrong, the whole batch had to be started over). This will allow for clinicians to make a diagnosis and provide appropriate treatment faster than had been possible previously. After 19 years with the previous instrument, Parkland has moved into the 21st century with HIV antibody testing.



This new test, developed by Ortho Clinical Diagnostic, is as accurate as previous tests but more specific to HIV, reducing the rate of false positives.

## Safety Stop

### Utility Failure ... Now What?

There is always a risk of utility interruptions at all hospitals, and these utility interruptions may occur at Parkland. Although it's a low probability, the severity may be high if experienced. Utility failure may include loss of electrical power, loss of water, medical gas, elevators, critical computer systems, etc. It is important that all Parkland employees know the appropriate response to these risks. The response by employees must be timely and should include who to call for assistance, what to expect while continuing operations in a backup mode and what interventions can help sustain operations.

**The Joint Commission requires that utility system users (employees) can describe or demonstrate:**

- Processes for reporting utility system management problems, failures and user errors
- Utility system capabilities, limitations and special applications
- Emergency procedures in the event of a system failure
- Location and use of emergency shutoff controls
- Whom to contact in emergencies

As part of their department-specific orientation, all employees must read the written utility management plan on the intranet and read EC Policy #80710-07-22, Utility System Interruption Notification Contingency Procedure.

The Environment of Care Committee will be testing employee knowledge concerning utility failure response during weekly environmental tours. For more information, look for the Utility Failure matrix poster on your units or on the Intranet under the Policy & Procedure Index, EOC & Safety Manual, 80710-07-23(1).

*The response by employees must be timely and should include who to call for assistance, what to expect while continuing operations in a backup mode and what interventions can help sustain operations.*



Once a code pink is in effect, knowing what to do can save a baby's life.

*With over 8,000 employees, not to mention a total of 40,000 people coming in and out of Parkland each day, we all have to be diligent in noticing everyone's identification.*

### *The WISH List*

#### **Code Pink – Do You Know What to Do?**

According to the National Center for Missing and Exploited Children, 177 babies were abducted from 1983 to 1998. One hundred of these were abducted from hospitals and 57 were taken directly from the mother's room. How does this happen? What can we do to prevent it? We need to be diligent in our roles and make sure this does not happen at Parkland, and if it does, we need to act quickly and appropriately in order to rapidly recover the missing child.

Most hospital abductions are by someone impersonating a hospital employee. A primary responsibility as a Parkland employee is to make sure everyone has an appropriate ID badge. Human Resources Procedure Manual # 6000-600 states that employees are "required to wear his/her employee identification badge while on duty" and it "must be worn high on the outer garment, no lower than chest level" with the picture visible at all times. With over 8,000 employees, not to mention a total of 40,000 people coming in and out of Parkland each day, we all have to be diligent in noticing everyone's identification.

#### **Other important risk-associated behaviors of abductors to be aware of include:**

- Repeated visits to "see the babies"
- Questions asked about hospital procedures (i.e. "When are feeding times?" "Where are the nearest stairwells?" "When are the babies taken to the mothers?")
- Babies being carried physically in the hospital (not in a basinet)
- Persons carrying large bags, purses, etc. away from patient rooms
- Targets rooms nearest stairwells or exits
- Sometimes creates diversions in other areas to distract from abduction

#### **What can we do if we suspect an infant/child abduction?**

- Attempt to STOP THE ABDUCTION
- Notify Police Dept. - call 911 immediately and activate Code Pink
- Notify the Charge Nurse
- Keep parents, guardians and relatives in the area
- Close the unit and LOCK IT DOWN (let no one in or out that is not properly identified and appropriate to be on the unit)
- Conduct a count of infants and children on the unit

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To aid in the prevention of abduction, we need to teach our patients and their families how to be active participants as well in the safeguarding of their baby.

- Watch your child at all times
- Know the hospital protocols involving infant care
- Identification Badges – pink and blue – what this means
- Know staff – question who people are
- Know where your child is going and the approximate time they will be gone (i.e. for labs, tests, procedures, etc.)

With the above outlined information, we can all work together to keep our campus safe for our patients, especially the little ones.

### Outpatient Observations

## Keeping Our Patients Safe

We are in the midst of cold and flu season, and many patients will come in complaining of coughs, runny nose, sore throat and fever. In most cases, these infections are temporary and harmless, but does your patient have the common cold or influenza?

Differentiating between a cold and flu may be difficult. In general, cold symptoms are nearly always less severe than those of the flu.

The following chart may guide you in your assessment.

Characteristics	Cold	Flu
<b>Onset</b>	Start rapidly with throat irritation and nasal congestion. Within hours symptoms develop, which include: sneezing, mild sore throat, minor muscle aches and coughing.	Abrupt onset of severe symptoms: headache, muscle aches, fatigue and high fever. Patients feel sick one to four days after exposure to flu virus.
<b>Fever</b>	Low grade or absent. In small children, it may be as high as 103 degrees F for one or two days.	Common and high (102-104 degrees F); lasts three to four days.
<b>Headache</b>	Rare	Almost always present
<b>General aches and pains</b>	Mild muscle aches if at all present	Extreme exhaustion is early and severe. Fatigue and weakness can last two to three weeks.
<b>Stuffy nose</b>	Nearly always. Discharge is usually clear and runny the first one to three days. Then thickens and becomes yellow to green in color.	Sometimes
<b>Sneezing</b>	Very common	Sometimes
<b>Sore throat</b>	Very common and lasts only a day.	Sometimes
<b>Chest discomfort and cough</b>	Mild to moderate hacking cough	Usually dry cough but can be severe
<b>Duration of symptoms</b>	Symptoms usually last two to seven days, although coughing and nasal discharge can last for more than two weeks.	Symptoms usually resolved in four to five days, although symptoms can persist beyond two weeks.

*Differentiating between a cold and flu may be difficult. In general, cold symptoms are nearly always less severe than those of the flu.*

Source: National Institute of Allergy and Infectious Disease  
 Resource: [www.cdc.gov/flu](http://www.cdc.gov/flu) --U.S. Centers for Disease Control and Prevention

## Med Surg Memos

### Wernicke-Korsakoff Syndrome



Symptoms of Wernicke's are mental confusion, ataxia and disturbances in eye movement. One may see stupor, hypotension and hypothermia.

Wernicke-Korsakoff syndrome or encephalopathy is a severe memory disorder generally associated with chronic excessive alcohol abuse. In general, Wernicke's is considered the acute form of the disease and is a precursor to Korsakoff's if not treated.

The cause of the disease is a thiamin deficiency due to poor nutrition and lack of absorption of the vitamin thiamin. Alcoholics tend to eat poorly, and the alcohol inhibits intestinal absorption of nutrients. However, the syndrome is also seen in non-alcoholics. Individuals with eating disorders, severe dietary deficiencies and those undergoing chemotherapy may develop this illness. Children are also affected by this disease. Severe thiamin deficiency actually causes damage to certain areas of the brain, especially the hypothalamus and the thalamus. These areas of the brain are important in the relay of information to other areas of the brain. Atrophy of the brain also occurs.

Symptoms of Wernicke's are mental confusion, ataxia and disturbances in eye movement. One may see stupor, hypotension and hypothermia. The hallmark of Korsakoff's syndrome, considered the chronic phase, is memory disorder, especially the ability of the patient to acquire and store new information and memories. Patients may exhibit tremors, lack of insight into illness, apathy and may become comatose. To compensate for the memory loss, patients may invent stories to fill in the blanks, a process called confabulation. The patient will be unaware that they are manufacturing memories.

Treatment consists of administration of thiamin, adequate hydration and proper nutrition. If treated early, the patient may recover, but if neurological damage and memory loss has occurred, recovery may be limited or nonexistent.

Prevention is simple: stop the alcohol and maintain proper nutrition.

## UAP Exclusive

### Rubella

*Man is the only host to the rubella virus, and transmission occurs by droplet emission from the nose or throat (coughing or sneezing) and respiratory secretions (mucus).*

Rubella is a contagious respiratory infection caused by a virus. Other names used for this infection are German measles and three day measles. Spring and summer months tend to have more cases than other times of the year. Before the vaccine was initiated in 1969, children between the ages of five and nine were primarily affected and many cases of congenital rubella occurred. Today, most cases appear in young, non-immune adults. It is estimated that 10 percent of young adults are currently susceptible to rubella. It is rare in the United States but still common in many parts of the world.

Man is the only host to the rubella virus, and transmission occurs by droplet emission from the nose or throat (coughing or sneezing) and respiratory secretions (mucus). During pregnancy the virus can also be passed to the fetus via maternal blood. The virus remains active and contagious on surfaces for up to two hours. Once the virus has multiplied in the airway, it will enter the circulatory system to affect other parts of the body. The incubation period can be 12 to 23 days before the patient begins feeling ill. Initial signs and symptoms can be minor respiratory symptoms, swollen lymph nodes in the base of the neck, mild fever (<102° F), rash and eye pain. The rash appears as a pink or light red flat spot on the face. Within one day the rash will fade but spread to the trunk and then the extremities. The rash may last three to five days. This period is when rubella is the most contagious. Serious complications are rare but include ear infections, pneumonia, encephalitis and Congenital Rubella Syndrome (CRS). There is no specific cure for rubella other than treating the symptoms (bed rest, fluids, Tylenol, etc.).

After recovering from rubella, a person has a lifelong immunity established. The rubella vaccine is also another method of acquiring immunity and has been shown to be 95 percent effective. All women of child-bearing age should be vaccinated prior to becoming pregnant in order to protect the baby.

## Good Catch—Patient’s are the Winners

December saw the conclusion of our first “game” for FY2009. It encourages submission of “near miss” events in PSN so processes needing improvement can be identified and worked on using a baseball game theme. The CPICU Tigers, MICU Royals and SICU Pirates participated in friendly competition in our Good Catch program during October through first part of December. All the winners were recognized on Dec. 17.



Game MVP Martin Flores, MICU

### TEAM WINNERS

Game Winner	MICU Royals – most PSNs with no patient harm
RBI Champ	MICU Royals – highest percent of B2s – caught and fixed before reaching patients
Home Run Champions	SICU Pirates – most PI projects resulting from PSNs during game
Error Free Game	SICU Pirates

### MVPS: Most PSNs with harm score B2 – caught & fixed before reached patient

Game MVP	Martin Flores, MICU
Honorable Mentions	Alisha Thomas, CPICU Steve Roe, SICU

### HOME RUN PI PROJECTS: Performance Improvement projects identified and begun during Game

SICU Pirates	Admission medical records with Pharmacy; skin care: Tissue Tuesdays; ventilator associated pneumonia project; blood wastage reduction; transfer to floor process; lab tube labeling
MICU Royals	Charge Nurse task list to improve ID and allergy bands, admission medication reconciliation record compliance
CPICU Tigers	Bed readiness

Congratulations to all involved. As processes improve, our patients truly are the winners. We would like to welcome our Rookie Teams for our next Good Catch game beginning this month: 6S--, 9SS G-Unit and BICU/BACU The Heat. Let the safety game begin!

### PSN REMINDER

Beginning this month, the Event Description (narrative) will be shared with facilities across the country. We don’t want any personal identifiers included, whether patient, visitor or staff. Use job title and ID number (or A, B, / 1,2, etc.) and put names in the section “Staff Providing Care,” as that won’t be shared outside of Parkland.

#### Example #1

- Wrong: Lab specimen for John Jones MRN# 123445 and req with Sally Smith MRN# 49201.
- Right: Lab req did not match specimen label (PSN demographic will have the name of patient for the lab specimen; put second patient info in “Staff Providing Care”: req = Sally Smith MRN#49201)

#### Example #2

- Wrong: Received patient from ED; no report prior to patient arrival; talked to Nancy Nurse, RN and Dr. John Smith and ...
- Right: Received patient from ED; no report prior to patient arrival; talked to ED Nurse AND patient’s physician and ... (in Staff Providing Care: “ED Nurse: Nancy Nurse; Physician: John Smith”)

Thanks for all the PSN reports that identify safety issues for our patients and staff. They enable us to identify our improvement opportunities.





*ESBL organisms can be spread directly by person-to-person contact or indirectly by contaminated environmental surfaces. This means that health care workers need to wear a gown and gloves before entering the patient's room.*

### *Infection Control*

#### **Extended-spectrum beta lactamase Producing Organisms (ESBLs)**

Extended-spectrum beta lactamase (ESBL) producing organisms are an increasing challenge for health care practitioners fighting health care-associated infections (HAIs). ESBL enzymes confer resistance to penicillins, cephalosporins and aztreonam in isolates of *Klebsiella pneumoniae*, *Klebsiella oxytoca*, *Escherichia coli*, *Proteus mirabilis* and other enteric gram negative rods. ESBL organisms are generally resistant to many other classes of antibiotics including aminoglycosides and fluoroquinolones. They are associated with increased mortality and are difficult to detect and treat.

The widespread use of extended-spectrum, third generation cephalosporins (ceftazidime, ceftaxime and ceftriaxone) introduced in the 1980s to treat antibiotic-resistant bacteria is believed to be a major contributor to the emergence of ESBL-producing organisms. The resistant strains produce ESBLs or enzymes that destroy penicillin or cephalosporin class drugs, thereby conferring resistance to those drugs. These very common bacteria, when they produce these enzymes, are much harder to kill with antibiotics. In the arena of Infection Control, ESBLs are considered multiply drug resistant organisms and need to be placed in Contact Isolation. This means that health care workers need to wear a gown and gloves before entering the patient's room. ESBL organisms can be spread directly by person-to-person contact or indirectly by contaminated environmental surfaces. Infection Control will identify and flag these patients in EPIC just like any other Contact Isolation organism. Patients should complete antibiotic therapy if they have one of these organisms and may need to be cultured after therapy to identify eradication of the organism and infection.

Please call Infection Control at ext. 28127 if you have any questions, and remember, hand hygiene and standard precautions are your best defense against the spread of disease.

### *Nutrition Consult*

#### **COPC Clinical Nutrition Services**

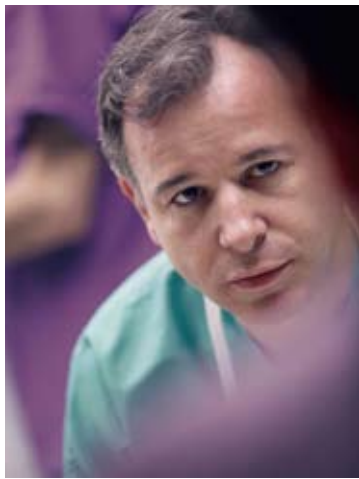
All COPC health centers have full-time or part-time services of Registered Clinical Dietitians. COPC Clinical Dietitians provide nutrition assessment and follow-up intervention to established COPC patients of all ages. Referrals for nutrition therapy are from the COPC primary care providers and other clinical staff within the clinic. Referral guidelines have been established to assist providers to identify high-risk patients needing nutrition assessment within a specified timeframe. Common problems or diseases that may require a nutrition assessment may include obesity, chronic heart failure, diabetes, failure to thrive in infants or children, unintentional weight loss in adults and malnutrition of any degree. Dietitians provide reassessment and follow-up intervention to monitor patient progress.

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Enteral nutrition support for tube feeding or oral supplementation is a service provided by the Clinical Dietitians within the COPCs. Primary care providers are encouraged to request a nutrition consult for patient assessment to determine calorie and protein needs and make recommendations for formula initiation, if appropriate. Monitoring and evaluation of patient progress is essential to this patient population. Each clinic site follows set procedures for charging and dispensing of enteral products and tube feeding supplies as determined by the Nutrition Services Department.

All Clinical Dietitians actively participate in the Diabetes Disease Management services at each clinic site. In addition to the diabetes classes, a variety of nutrition classes are also offered in the COPCs based on patient needs. These classes may include Adult Weight Management, Pediatric Weight Management and Cardiovascular Nutrition. COPC Dietitians are also participating in COPC Shared Medical Appointment group visits with Physicians, Social Workers and Health Educators.

Questions related to the nutrition services available at each COPC clinic site may be addressed to the nutrition office at each site or Delia Solis, Clinical Nutrition Manager-COPC/OPC at ext. 20808 or dsolis@parknet.pmh.org.



### *Regulatory Round-up*

## **2009 Joint Commission Survey**

Our hospital is expecting a triennial survey from the Joint Commission sometime in 2009. This survey will be unannounced. We are expecting five or more surveyors to show-up, most likely on a Monday morning. Whoever comes in contact with the surveyors must request to see their official Joint Commission identification and call the Regulatory Department for confirmation. The surveyors will be escorted to Administration. During the visit, surveyors will be in all areas of the hospital and clinics, including inpatient and outpatient areas. Staff from the Regulatory and Performance Improvement departments will be escorting all of the surveyors through the hospital and clinics. If you should come in contact with any of the surveyors, here are a few tips to help you:

- Be flexible, but be ready for a surveyor to ask you questions about what you do and how you do it.
- Be polite to the surveyor when answering questions.
- The patient comes first. If the surveyor needs some of your time, make sure your patients are being covered by another staff member.
- Use open body language – face the surveyor and make eye contact. Never cross your arms.
- Answer questions with “yes” or “no,” when appropriate. Don’t elaborate unless you’re asked to do so.
- If you do not understand the question, ask the surveyor for clarification.
- If you do not know the answer to a question, let the surveyor know that you will get the answer for him/her. Don’t try to guess the answer.
- Try not to be nervous. If a surveyor is observing you, focus on the patient and the task/procedure being provided.
- Relax—surveys are your opportunity to show the exceptional job you do every day.

*The patient comes first. If the surveyor needs some of your time, make sure your patients are being covered by another staff member.*



*Pharmacists provide a unique perspective and are able to assess the patient for medication-related issues.*

## *Pharmacy*

### **ALTEPLASE (TPA) PREPARED BY THE PHARMACIST**

Alteplase® is a treatment option for some stroke patients. These patients must receive a bolus dose in addition to a continuous infusion. In order to ensure the correct bolus is being administered to the patient, the Pharmacy Department will prepare and dispense the bolus dose separately in a syringe. The remaining amount will be reconstituted in the vial for the continuous infusion. Following the continuous infusion, Pharmacy will retrieve the empty vial.

### **PARKLAND PHARMACIST PARTICIPATION IN CODE BLUE RESPONSE**

Pharmacists will now respond to code blue events as a primary member of the response team to assist in medication preparation/hand offs to code team members. Pharmacists completed two training sessions: I. Pharmacotherapy resuscitation medications, II. Practical-using sample cart and patient cases.

Pharmacists began responding to codes on Jan. 19.

### **HOSPITALS SEE VALUE IN ADDING PHARMACISTS TO RAPID-RESPONSE TEAMS**

Stanford Hospital and Clinics in Stanford, California and Parker Adventist Hospital in Parker, Colorado report that pharmacists originally were not included in their rapid response teams. However, the teams have found that the inclusion of pharmacists has greatly benefited their calls. Pharmacists provide a unique perspective and are able to assess the patient for medication-related issues. When the rapid response teams are activated at Parker Adventist Hospital, the pharmacist brings a set of medications. Upon arrival at the patient's bedside, he/she assesses the patient to determine whether there are issues present that pharmacy can help resolve. For example, if the patient is having a seizure, the pharmacist will determine if their home medications were restarted, if the dose is adequate and if serum concentrations are being monitored.

Administrators at the Stanford and Parker facilities are working to document and monitor rapid response team calls in order to evaluate their impact on patient outcomes. So far, Stanford reports that the rate of non-ICU cardiopulmonary arrests has decreased and the facility is planning to expand the rapid response team to other facilities in their hospital system.

The Institute for Healthcare Improvement, a group dedicated to improving the quality of health care worldwide, suggests that pharmacy be involved to some extent on rapid response teams and encourages pharmacists to be proactive in letting administrators know their potential value in the process.

**Reference: 1. Traynor Kate. Hospitals See Value in Adding Pharmacists to Rapid-Response Teams. January 15, 2009. AJHP News. <http://www.ashp.org/import/news/HealthSystemPharmacyNews/newsarticle.aspx?id=2993>. Accessed January 12, 2009.**

## *Notes from Nursing Administration*

### **The Case for Preventing Hospital-Acquired Pressure Ulcers**

The Institute for Healthcare Improvement (IHI) has identified pressure ulcers as a preventable medical harm event. This article begins a series detailing the background and essential elements of care recommended by the Institute's *Protecting 5 Million Lives from Harm Campaign*.

A pressure ulcer is a localized injury to the skin and/or underlying tissue. Pressure ulcers most commonly occur over bony prominences as a result of pressure, shearing and friction. Because muscle and subcutaneous tissues are susceptible to injury, pressure ulcers may actually be worse than they initially appear. Therefore, careful staging is crucial to the evaluation and treatment of a pressure ulcer.

Pressure ulcers are painful, increase patient recovery time and predispose the patient to significant infection resulting in increased length of stay, sepsis and increased mortality. It is estimated that nearly 60,000 U.S. hospital patients die each year from hospital-acquired pressure ulcers.

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One of the tenants of the 5 Million Lives Campaign is the belief that pressure ulcers are preventable in most every case. However, pressure ulcer incidence rates vary considerably by clinical setting and are rising in health care facilities. It's estimated that pressure ulcer prevalence in acute care is 15 percent and that 2.5 million patients are treated for pressure ulcers in U.S. health acute-care facilities each year. The estimated cost for managing one single full-thickness graft is as high as \$70, 000 and the total cost is estimated at \$11 billion per year.

The case for preventing hospital-acquired pressure ulcers is an easy one for both the patient and hospitals. Next month we'll begin to examine how to get started with The First Essential Element: Admission Skin Assessment.

**Reference: 5 Million Lives campaign. Getting Started Kit: Prevent Pressure Ulcers How-to Guide. Cambridge, Ma: Institute for Healthcare Improvement; 2008**

## *Respiratory Tidings*

### **Update: The Care of Tracheostomy Patients in the General Care Areas**

To improve the quality of care delivered to our tracheostomy patients in the general care areas, a new process was implemented in Oct. 2008. All tracheostomy procedures have been reviewed and revised (a complete list of all tracheostomy procedures is provided below) and a new administrative procedure for tracheostomy capping (06-45) has been developed.

Each caregiver now has a defined role in the tracheostomy capping process and stop capping criteria have been defined. In addition, all staff charting related to a tracheostomy should be done on a multidisciplinary tracheostomy flow sheet (FORM # 4405). This 24-hour flow sheet should be at the bedside of all tracheostomy patients and each unit is responsible for putting a new flow sheet at the bedside by 7 a.m. Of special importance is the change in safety equipment required at the bedside. The list below highlights some of the major changes:

*Each caregiver now has a defined role in the tracheostomy capping process and stop capping criteria have been defined.*

#### **SAFETY EQUIPMENT REQUIRED TO BE AT BEDSIDE**

- Functional suctioning
- Suction catheters
- Extra cuffed tracheostomy tube (same size of existing trach)
- Obturator

#### **STOP CAPPING CRITERIA**

- Heart rate 20 percent change from baseline
- Respiratory rate greater than 35 bpm for five minutes
- SPO2 less than 90 percent for greater than 30 seconds
- Blood pressure greater than 20 percent change from baseline

#### **REVISED PROCEDURES/POLICIES**

- Respiratory Care
  - RCT- O-1 Oximetry monitoring
  - RC T-2: Tracheostomy Care
  - RC C-3: Continuous Aerosol Therapy
  - RC O-4: Tracheal Suctioning
- Nursing
  - NSG-34-01
  - NSG-34-05
  - NSG-34-06
  - NSG-34-12
- Speech Therapy
  - ST Procedure Number: 7093.4A
  - ST Procedure Number: 7093.4B
  - ST Procedure Number: 7093.4E



## **American Board of Physical Therapy Specialties Recognize Board Certified Specialists**

The American Board of Physical Therapy Specialties of the American Physical Therapy Association has awarded specialist certification to 835 physical therapists nationwide this year. These board-certified specialists completed the necessary requirements for the following specialty areas: Orthopaedics, Neurology, Geriatrics, Sports, Pediatrics, Clinical Electrophysiology and Cardiovascular & Pulmonary. To obtain Board Certification, candidates must submit evidence of required clinical practice in a specialty area. In addition, candidates must successfully complete a rigorous written examination, demonstrating specialized knowledge and advanced clinical proficiency in a specialty area of physical therapist practice.

To date Texas has a total of 222 Board Certified Clinical Specialists in Orthopaedic Physical Therapy and 4979 nationwide. We are proud to announce that Parkland has three such accomplished therapists working in our physical therapy department. Shanan Richard and Emily Tippett were both certified as a Clinical Specialist in Orthopaedic Physical Therapy by the American Board of Physical Therapy Specialties this year. Micah Propps obtained her board certification June 2006. Parkland is unique in employing more clinical specialists in orthopaedic physical therapy than any other hospital system in the Dallas-Fort Worth Area. In addition to the above accomplishments, all three therapists are pursuing a Post-Professional Doctorate Degree in Physical Therapy.

Physical Therapists are health care professionals who diagnose and treat individuals of all ages, from newborns to elders, who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities in their daily lives. Physical Therapists examine each individual and develop a plan of care using treatment techniques to promote the ability to move, reduce pain, restore function and prevent disability. Physical Therapists also work with individuals to prevent the loss of mobility by developing fitness-wellness-oriented programs for healthier and more active lifestyles. The American Physical Therapy Association established specialist certification as a mechanism to formally recognize physical therapists who have demonstrated advanced clinical knowledge and skills.



### **Patient Education Update**

*Education is not the filling of a bucket, but the lighting of a fire. – W. B. Yeats*

#### **Which qualities constitute the type of teacher who lights fires?**

Beth Lewis says, "The teachers I admire most are those who remain intellectually curious and professionally vital both inside and outside the classroom for decades. They avoid stagnation at all costs and maintain an enviable passion for their students and the learning process. They remain vivid in the students' memories forever because of their creativity, sense of fun and compassion."

Most of us can look back through the years of our schooling and remember teachers – the good ones, and the ones who have hurt us in some way.

#### **How can we be one of the teachers that learners remember with gratitude and affection?**

- Passion for students, subject and process – they are authentically interested in and engaged with each student. They take the time and effort to stay "expert" in their area of expertise. "They embrace new technologies and confidently move forward into the future."
- Creativity – don't mistake this with being "artsy-craftsy." It means putting in the thought, willingness and effort in to make learning experiences "exciting and memorable."
- High expectations – in part because "expectations form a self-fulfilling prophecy." The learners "sense that confidence and work with the teacher to make it happen."
- Sensitivity and compassion – "The best teachers live outside of their own needs and remain sensitive to the needs of others, including students . . . colleagues and the community."
- Versatile – are aware that learners have varying needs and varying learning styles. Good teachers assess and reassess, and have a repertoire of behaviors and skills they can draw on as needed to help the learner "get it."
- Understand the value of fun and humor in "learning and in life." Great teachers know that "we can have fun while we get work done."

**While the points above are not directly from Lewis's list, all the quotations are. Lewis, Beth. *6 Traits of Successful Teachers*. About.com Elementary Education, 2009. <http://k6educators.about.com/od/professionaldevelopment/p/successteach.htm?p=1>.**