

Clinical Care Connection

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

Changes in Administration Guidelines

Phenergan® (promethazine) is a first-generation H1 receptor antagonist, antihistamine and antiemetic medication. Phenergan is administered in the hospital setting predominantly for nausea and vomiting and has a pH between 4 and 5.5, which is highly caustic to blood vessels and soft tissue. The recommended route of administration is deep intramuscular into a large muscle due to significant tissue damage that can occur from IV, subcutaneous or inadvertent intra-arterial administration.

There have been multiple reports of patient injury from Phenergan IV administration in hospitals across the country. Following these reports, safe practice guidelines have been published to help prevent or minimize tissue damage when administering a Phenergan IV. Parkland has recently changed administration guidelines for Phenergan IVs to be consistent with these recommendations.



Discuss alternative medications or IM route of administration with the physician.

Alternatives available on formulary include:

- Prochlorperazine 10mg IV q eight hours prn for patients under the age of 60; drug of choice for opioid-induced and post-op nausea and vomiting
 - Recommended first line for opioid induced and post-op nausea and vomiting
 - Administration: for IV push do not exceed 5mg/minute
- Prochlorperazine 5mg IV q eight hours prn for patients age 60 or older; for nausea and vomiting
 - Recommended first line for opioid induced and post-op nausea and vomiting
 - Administration: for IV push do not exceed 5mg/minute

(‘Phenergan’ continued page 2)

IN THIS ISSUE

- 2 Leadership Loop
Sprinkler Head Clearance
- 3 Singing the Holiday Blues
Clinical Care and Emergency Services Residency Update
- 4 Strategies for Precepting the Challenging Student
- 5 What is RALS-Plus? And What Does it Mean for Parkland?
Pathology Phlebotomy Expansion: Jan. 5
- 6 Keeping our Patients Safe
- 7 Chickenpox
Pertussis on the Rise
- 8 The Neuro Exam Using the Glasgow Coma Scale
- 9 Focus on Obstructive Sleep Apnea (OSA) in the Post-Operative Patient
- 10 Pharmacy and Therapeutics Committee
- 11 Gestures Aid in Learning
Update on Patient Education Materials
- 12 Patient Safety Net (PSN) Reports
Services for Deaf, Hard-of-Hearing and Speech-Impaired Citizens

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Leadership Loop

Have you ever looked closely at the branches on a tree? There are little green ones that bend and sway with the wind and never seem to break, and there are the dry and brittle ones that break when the strong winds blow. Sometimes we are like these branches. There are people that are constantly up to the challenge of trying new things, trying to improve and willing to do what it takes to get their job done. These people are like the little green branches on the tree; they can bend and adjust easily to change. There are also a few of the dry brittle branches lurking around. These are the people that have a difficult time with change, and are not interested in trying new ways since the old ones work well.

It is such an exciting time to work at Parkland. There are so many positive things happening, and to top it off, we get to have a new hospital. Our employees make Parkland great, what kind of employee are you? Are you the green branch that is willing to bend and change as needed, or are you the brittle one that will break if the wind changes direction? With the new year, I challenge all of us to be green branches. Let's continue to do what it takes to help our patients and keep Parkland great.

Phenergan *(continued from page 1)*

- Ondansetron 4mg IV push q six hours prn for nausea and vomiting
 - Recommended first line for chemotherapy induced nausea and vomiting and second line for patients unable to tolerate prochlorperazine
 - Administration: undiluted over 2-5 minutes

If alternatives are not appropriate for the patient, follow these recommendations.

- Dilute the medication in 10-20mls of normal saline.
- Administer the drug slowly. Push the medication over 10-15 minutes. Infusing through a syringe on line B of the Hospira pump is recommended.
- Check patency before each injection of Phenergan. Use extreme caution to make sure you do not inadvertently inject Phenergan intra-arterially or subcutaneously.
- Use a large bore IV in a large vein. Verify the IV catheter is at least an 18 gauge. Do not push the medication into an IV in the hand.
- Push the medication into the port furthest from the patient. Do not inject directly into a capped IV.
- Administration into a central line is preferred.

Significant complications from Phenergan administered IV include: burning, redness, pain, swelling, vessel spasm, thrombophlebitis, venous thrombosis, phlebitis, nerve damage, paralysis, abscess, tissue necrosis and gangrene. If the patient complains or shows signs of tissue injury, notify the physician immediately. Although there is no definitive treatment, early intervention may be effective in minimizing tissue damage. The most severe complications may require surgical debridement, fasciotomy, skin graft or amputation.

If you have questions or concerns, please discuss with your nurse manager, satellite pharmacist or nurse educator.

REFERENCES

The Institute for Safe Medication Practices (www.ismp.org), search word Phenergan

Wikipedia (www.wikipedia.org), search word Phenergan

MedicineNet.com (www.medicinenet.com), search word promethazine

The online PHHS Drug Formulary (www.crlonline.com), changes will be reflected on 2.11.2009 for this site

The Safety Stop

Sprinkler Head Clearance

Recent Environment of Care Committee tours have shown a repeat violation and trend where storage areas have supplies stacked so high as to block fire sprinkler heads. This causes an unacceptable life safety risk and is also a Joint Commission violation.

Sprinkler Heads Must Remain Clear by 18"

NFPA 13-1999:5-8.5.2.1 requires there be 18 inches or more of open space maintained below a sprinkler head deflector to the top of storage. This assures the sprinkler system will operate correctly, adequately dispersing the extinguishing agent and suppressing the fire in a Code Red emergency.

During weekly environmental tours the Environment of Care Committee has found numerous violations of this important life safety rule, mainly in storage areas where boxes and supplies are stacked all the way to the ceiling. Compromising the 18 inch rule creates an unsafe fire and life safety risk and makes the hospital vulnerable for a Joint Commission RFI.

Engineering has been installing red tape at the 18 inch level in storage areas to help provide a visual indication of compliance. Department leaders can help by assuring storage areas are marked with the red tape, by educating employees and by enforcing the 18 inch rule in their unit storage areas.

Note: Perimeter wall shelving may extend up to the ceiling when not located directly below a sprinkler head.

Outpatient Observations

Singing the holiday blues

The holiday season is full of cheer, parties and general fun. But, it can also be a time of loneliness, sadness, anxiety and depression.

These symptoms and others are attributed to seasonal affective disorder (SAD) and can be destructive to a person's work and personal life.

SAD is a mood disorder associated with seasonal variations of day length. Symptoms can begin in the fall, usually peak in the winter and subside completely in the spring. As seasons change, our "biological internal clocks," which regulate circadian or 24-hour rhythms, are altered due partly to sunlight pattern changes. As a result, our normal daily schedules are out of sync with our biological clocks.

"In addition to SAD, other health problems are likely to accompany the effects of shorter day length during the winter on the biological clock," said David J. Earnest, Ph.D., professor in the Department of Neuroscience and Experimental Therapeutics at the Texas A&M Health Science Center-College of Medicine. "For example, we know that circadian rhythm disturbances or pathologies play a role in diabetes, obesity, cancer and cardiovascular accidents."

SAD sufferers are more likely to be affected in January and February, and women are at higher risk, experiencing 70-80 percent of SAD cases.

Melatonin, a sleep-related hormone produced at increased levels in the dark, is thought to be an important factor in SAD as well. When days are shorter and there is less light in the winter, night-time melatonin levels are produced for a longer period of time, perhaps bringing about depression symptoms.

Doctors often prescribe phototherapy or bright light therapy for SAD sufferers, though studies also have shown an hour's walk in winter sunlight can be just as effective as 2.5 hours under bright artificial light. If you're suffering from the "winter blues," talk to your doctor about the possibility of SAD, said Dr. Earnest, who maintains a website on circadian research at <http://medicine.tamhsc.edu/clocks/home.html>.

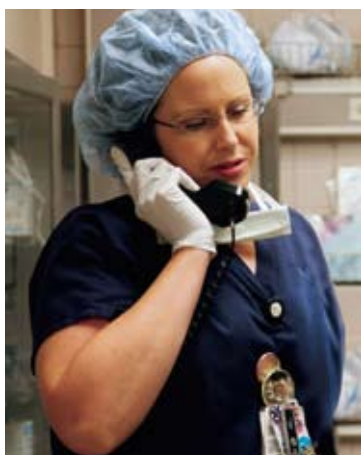
Source: <http://medicalnewstoday.com>



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Critical Care Vital Signs

Critical Care & Emergency Services Residency Update



Do you ever wonder how many nurse residents complete the residency program during a year? Hold on to your seat, it is approximately 120 per year. The Surgical ICU and Emergency Services Department seem to have the largest number of participants per residency, averaging approximately 12-15 participants per unit. The next question is - do they all stay? Unfortunately the answer is no.

Many of you will recall the stress and pressure of the residency program. Some participants choose to leave during the residency due to this stress, or they just find it is not a good fit. Participants have an ideal of the environment in which they want to work, but they find it is not always what they thought it was.

The reasons participants leave after completing the residency vary from moving away, wanting to work closer to home and to advance their education by attending Certified Registered Nurse Anesthetist or Nurse Practitioner school.

The retention seems to be to the term of the contract, which is two years after graduation. This turnover rate will continue since Parkland is such an incredible, fast paced, learning environment. The adrenaline rush of caring for the critical care patients will never cease. It seems to be a stepping stone for health care professionals. However, while those that grow as a critical care nurse at Parkland may leave, they often find their way back, because this environment is truly one of a kind.



The most important goal as a preceptor is to try as hard as possible to prevent unsafe practice from occurring.

The WISH List

Strategies for Precepting the Challenging Student

A recent study suggests several strategies particularly useful for precepting the challenging or struggling student. The most important goal as a preceptor is to try as hard as possible to prevent unsafe practice from occurring. This can be accomplished by familiarizing yourself with course expectations, orienting students to your unit and sharing expectations with the students or setting clear expectations and goals with them. For example, sharing expectations with students is important because a clear understanding of the preceptor's expectations and goals may assist students to adapt more readily to the new environment and avoid significant problems.

Most of the preceptors in this study identified hallmarks of unsafe practice very early in the rotation. Preceptors are encouraged to, whenever possible, try to gather data from all possible sources including the nurse educator or clinical instructor to be able to decide on an appropriate plan of intervention for students.

Strategies recommended by the preceptors in this study for managing an unsafe student included documentation as an essential step in the process of addressing unsafe practice situations. The preceptors also recommended having the student perform a self-assessment to establish his or her perspective on the situation. This process is particularly important because some students may lack awareness of their incompetence, thus requiring more specific feedback.

Some preceptors in this study suggested jointly setting up and documenting a detailed action plan to provide the student with the learning opportunities to enable the student to improve. Regardless of the severity of the problem, preceptors are encouraged to contact the faculty instructor or nurse educator so they can receive advice, guidance and support.

In the clinical setting, unsafe practice must be resolved immediately, often with the preceptor taking over the task. Preceptors must take a more proactive coaching role by guiding students in patient care activities using demonstrations, cues, prompting questions and constructive feedback. Preceptors should give immediate corrective feedback during and after performance or when errors occur. Give timely, specific, honest, ongoing and constructive feedback in private.

This study also highlighted the importance of a good learning environment, largely influenced by the student-preceptor relationship and the relationship between the student and the greater health care team. Studies suggest that the staff is a key figure in establishing and maintaining an atmosphere conducive to learning in the clinical setting. One preceptor encouraged colleagues to reflect on their own practice to ensure that they are practicing within the acceptable standard of practice before concluding that the student is unsafe. This is crucial because some preceptors may think that their own way of performing procedures is the only right way.

Although preceptors acknowledged that working with students with unsafe practice could be stressful, especially with students continually following and asking them questions, they were still willing to be patient and supportive with such students. It is necessary for preceptors to be empathetic, remembering what it was like to be a student. Preceptors need to let the student know that they will try to work through the problem together and that they will work with the instructor or educator to provide support for learning to take place.

Laboratory Scope

What is RALS-Plus? And what does it mean for Parkland?

Remote Automated Laboratory System (RALS-Plus) is the most widely used connectivity system solution for Point of Care analyzers. The focus of the system is on integrated data management, such as quality control and patient result data. Other features of the system include regulatory compliance, downloading results to other computer systems, improving charge capture, increasing efficiency for our Point of Care Coordinators, Steven Lee and Aziz Lakhani, and enhancing patient safety.

Phase I of this multi-phase project will network glucose analyzers throughout Parkland, capturing all patient and controlling data in a central server. Various reports can be generated for regulatory or investigational purposes. Pathology personnel will no longer have to download analyzer data to a laptop computer.

Phase II will involve an interface from EPIC and another one to Cerner (LIS). The EPIC interface will be set up to display the patient name on the glucose analyzers when the patient identification number is entered. This helps to ensure the correct entry of a patient ID by giving a second check on the patient's name before testing. This feature aids in compliance with two patient identifiers required by both The Joint Commission and CAP.

The purpose of the Cerner interface is to download patient results into Cerner, which will then transmit the results to EPIC so that nurses and providers can view the results with no transcription errors. This process will also automate patient charges for glucose testing, many of which are not currently charged.

In Phase III, we will introduce the i-STAT interface and modules for Tight Glycemic Control (TGC), eQUIZ and Other Test Entry (OTE). Additional phases will include networking of urine dipstick and hemoglobin analyzers. The next generation of glucose analyzers will also be wireless, allowing real-time data transfer.



The focus of the system is on integrated data management, such as quality control and patient result data.

Pathology Phlebotomy Expansion: Jan. 5

Great news! The phlebotomy team will be offering more collection times to collect routine blood samples. At 5 a.m., Jan. 5, we will start hourly collections as follows:

5 a.m.	Medicine units (10E/W, 9E, 9W, 9S, 9SS, 8N, 8E, 8W, 8SS, 7SS, 7E)
6 a.m.	Surgery/WISH units (7S, 7N, 6E, 6W, 6S, 5N, 5E, 5W, 5S, 2W, 4 Newborn Nursery, 4N, 4E, 4W, 4S, 3N, 3E, 3W, 3 Newborn Nursery, rooming in, CCN and Neonatal ICU)
7 a.m.	Medicine
8 a.m.	Surgery/Wish
9 a.m.	Medicine
10 a.m.	Surgery/Wish
11 a.m.	Medicine
Noon	Surgery/Wish
1 p.m.	Medicine

In order to serve you better, the phlebotomy team will offer additional collection times from 5 a.m. to 1 p.m., Jan. 5, 2 to 10 p.m., March 4 and 11 p.m. to 4 a.m., July 1.

Notes from Nursing Administration

Keeping Our Patients Safe

Limiting Patient Falls and the Unplanned Removal of Tubes and Lines

The Center for Medicare and Medicaid Services (CMS) has recently classified elbow immobilizers as restraints. A provider order is needed to place elbow immobilizers on a patient. Our patients have benefited from the use of low beds and a variety of devices intended to limit the removal of medical devices. Please continue to utilize these products. Also, we have a new product to limit falls. Siderail extenders are now available for the Hillrom beds for patients who are at-risk of falling over the siderail. The ordering information and product descriptions are listed below. Please call Venita Dasch at ext. 25847 with questions.

Product Name	Order Information	How does it work?	Nursing Care	Disposable	Restraint Order needed?
Low Beds	Call Patient Rental Equipment ext. at 28014.	Limits falls with injury by allowing patient to climb out of bed and sit on floor. Low beds are kept at Parkland so there is no waiting for delivery	Keep the bed in low position at all times when not with patient. Do not use on patients with drainage tubes, IV pumps or other objects that could become dislodged or be pulled over on the patient.	No	No
Posey Freedom Splint DeRoyal Elbow Immobilizers	Order from MRD Medium - #20305 Large - #20304 #20306	Limits ability to bend elbows to pull on tubes, lines and dressings.	Remove the product every shift to assess skin and perform a range of motion per unit standard.	Yes	Yes
Skin Sleeve	Order form MRD Medium - #23890 Large - #23891	Covers a peripheral dressing with a close-fitting sleeve, limiting the ability to remove the dressing.	Remove the product every shift to assess skin and perform a range of motion per unit standard.	Yes	No
Finger Control Mitten	Order from MRD #10090	Limits the ability to grasp objects.	Remove the product every shift to assess skin and perform a range of motion per unit standard	Yes	Only if secured to a stationary object
Palmer Hand Control Mittens	Order form MRD #10091	Limits the ability to grasp objects. A ball in the palm of the hand diversional activity for some patients.	Remove the product every shift to assess skin and perform a range of motion per unit standard.	Yes	Only if secured to a stationary object
Posey Socks	Order from MRD Pedi - # 20929 Regular - #20931 X-large - #20934	Non-skid surface limits slips when out of bed.	Remove the product every shift to assess skin.	Yes	No
Posey Mobile Seatbelt Sensor and Keep Safe Alarm Unit	Order form MRD Seatbelt - #38371 Alarm - #38350	The seat belt secures patient in a chair. If the patient unlocks the belt, an alarm will sound.	Remove the product every shift to assess skin and perform a range of motion per unit standard.	No	Only if buckle placed behind patient
Posey Bed Sensor and Keep Safe Alarm Unit	Order from MRD Sensor - #38307 Alarm - #38350	Mattress pad sounds an alarm when the patient attempts to exit the bed.	Remove the product every shift to assess skin.	No	No
New Product					
Hillrom Siderail Extenders	Patient Rental Equipment SP 5167735 Fax or bring down a miscellaneous order to Patient Rental Equipment. Faxed orders will be delivered by PRE. Order brought down by staff will be filled immediately	Extends siderail height to limit falling over siderail.	Secure to the bed by a simple locking pin.	No	No

Unlicensed Assistive Personnel Exclusive

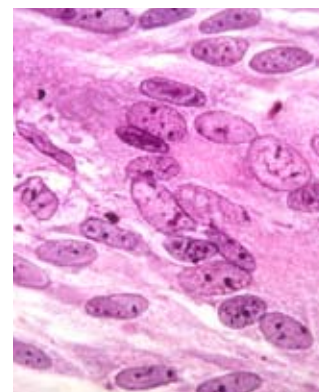
Chickenpox

Chickenpox is an acute viral infection caused by the varicella zoster virus (VZV). The primary infection results in varicella or chickenpox with possible recurrent infections of shingles. Transmission of the virus is respiratory initially with multiplication in the nasopharynx and regional lymph nodes in the upper airway. Further multiplication affects the liver, spleen and sensory ganglia and finally the skin. The incubation period is usually 14-16 days before lesions appear on the head, eventually spreading to the torso, then the arms and legs. The lesions usually range in size from 1 to 4 millimeters beginning as a flat red area evolving into a blister which eventually ruptures and crusts over. Symptoms accompanying the lesions are malaise, itching and a temperature of 102° F for 2-3 days. Treatment includes Tylenol or ibuprofen, calamine lotion, bed rest and cool baths with baking soda. Antibiotics may be prescribed for bacterial infections.

Complications of bacterial infections, pneumonia and meningitis or encephalitis may occur in infants under one year of age and those over the age of 15. Mortality is greatest in the adult group.

Isolation is important as chickenpox is very contagious. Airborne and contact isolation should be initiated for all patients with chickenpox. Transmission via airway occurs before the appearance of lesions. Once blisters appear then rupture, fluids within the vesicles contain the varicella virus and are infectious. After a crust develops over the lesions, the patient is no longer infectious.

Recovery from chickenpox results in a life-time immunity. A vaccine is also available to provide immunity and is recommended for children as young as 12-15 months old as well all other susceptible individuals. Immunization is recommended for all health care workers.



Chickenpox is extremely contagious, so isolation is important. Airborne and contact isolation should be initiated for all patients with chickenpox.

The Infection Connection

Pertussis on the Rise

Pertussis has been on the rise in the Texas, mirroring a national trend. There have been 1,247 cases reported through Nov. 29, compared to 795 for all of 2007. Parkland has had five cases this year.

Pertussis, or “whooping cough”, is a highly communicable respiratory infection caused by *Bordetella pertussis*, a gram-negative coccobacillus. The disease is typically more severe in infants and young children. Infection in adults and adolescents may be asymptomatic or may present as classic pertussis. The incubation period is typically 5-10 days.

Early symptoms, called the catarrhal stage, are similar to the common cold: mild fever, runny nose and cough. The patient is most infectious during this stage, which lasts 1-2 weeks. Symptoms typically progress to severe episodes of paroxysmal coughing, which may be followed by vomiting. Coughing spells can last more than 100 days and may lead to a hernia or broken rib. The high-pitched “whoop” associated in the disease is uncommon in adolescents or adults, which may make the disease difficult to recognize. Fever is usually minimal throughout the course of the illness. Convalescence may take weeks to months. Complications are more common in infants and young children and include hypoxia, apnea, pneumonia, seizures, encephalopathy and malnutrition.

Pertussis is spread from droplets produced when an infected person coughs or sneezes. Up to 90 percent of susceptible household contacts may develop the disease after exposure. A patient suspected of having pertussis should be placed in Droplet Precautions (private room, surgical mask for all who enter) for five days after initiation of effective therapy. Occupational Health should be notified if a susceptible employee has unprotected exposure.

Prevention is primarily by vaccination. Adolescents and adults become susceptible when immunity from vaccination as a young child wanes. In 2005, the Federal Drug Administration approved an acellular pertussis vaccine to be administered as a booster to adolescents and adults. It is also recommended for health care workers with direct patient care. As with any vaccine, there are contraindications and risks. Occupational Health Services administers the Tdap (tetanus toxoid, diphtheria toxoid, acellular pertussis) vaccine to employees who may be at risk.

The high-pitched “whoop” associated in the disease is uncommon in adolescents or adults, which may make the disease difficult to recognize.

Never assume that just because your patient has had the same exam all day that it has not changed. The one time you miss doing the exam will be the time that some bad or good change has taken place.



Med Surg Memos

The Neuro Exam Using the Glasgow Coma Scale

The Glasgow Coma Scale (GCS) provides an easy way to describe a patient’s baseline mental status and to help detect and interpret changes from baseline findings. When using the GCS we test the patient’s ability to respond to verbal, motor and sensory stimulation and grade those findings according to the scale. The patient, who is alert, oriented to person, place and time and follows simple commands would receive a score of 15. A score of 8 or less indicates a severe neurological problem.

Remember, you want the patient to receive the best score possible. Make sure you give them sufficient time to answer your questions or to follow commands. Sometimes their response may be delayed. If your patient is difficult to arouse try opening the blinds, turning on the lights and really waking them up. It is very important to make sure to do your neuro exams as ordered and sometimes more frequently if you feel something may not be quite right. NEVER assume that just because your patient has had the same exam all day that it has not changed. The one time you miss doing the exam will be the time that some bad or good change has taken place.

Glasgow Coma Scale for Head Injury

EYE OPENING		VERBAL RESPONSE		BEST MOTOR RESPONSE	
Spontaneous	4	Oriented	5	Obeys	6
To loud voice	3	Confused, disoriented	4	Localizes	5
To pain	2	Inappropriate words	3	Withdraws (flexion)	4
None	1	Incomprehensible sounds	2	Abnormal flexion posturing	3
		None	1	Extension posturing	2
				None	1

Pain Points

Focus on Obstructive Sleep Apnea (OSA) in the Postoperative Patient

Mr. Smith (fictional name) is a 60-year-old African American man scheduled for Cholecystectomy. He is six feet tall, 300 pounds with a neck circumference of 18.5 inches (47 cm.). His past medical history includes hypertension, diabetes and loud snoring with significant daytime somnolence.

HOW WOULD YOU RATE MR. SMITH'S RISK FOR OSA AND RESPIRATORY DEPRESSION AFTER SURGERY?

Low Risk Intermediate Risk High Risk

Mr. Smith quite likely has undiagnosed sleep apnea, placing him at high potential risk for respiratory depression, especially during the first few postoperative hours. Most persons who have signs and symptoms of OSA have not been diagnosed. The gold standard for diagnosing OSA is polysomnography (a sleep study), a time-consuming, expensive test that is not readily available. We must often assume OSA is present and manage accordingly, or defer elective cases until a sleep study can be done.

WHAT IS OSA?

OSA consists of episodes of partial or complete closure of the upper airway that occur during sleep and lead to breathing cessation. It is the absence of airflow in the presence of respiratory effort.

WHAT ARE SOME GENERAL FACTORS TO HELP IDENTIFY OSA IN ADULTS?

- Loud snoring
- Observed apnea
- Obesity (BMI of 35 kg/m² or more)
- Neck circumference > 40 cm
- Tiredness during daytime
- High blood pressure
- 50+ years of age
- Male

WHAT ARE SOME GENERAL FACTORS TO HELP IDENTIFY OSA IN ADULTS?

- Anticipate longer PACU recovery time to monitor respiratory status.
- Anticipate increased respiratory assessments by RN on the ward.
- Elevate HOB to 30 degrees or more, unless contraindicated.
- Consult respiratory therapy for APAP, CPAP or BiPAP. Patients may supply their own CPAP from home. Apply when patient is sedated, sleeping or supine.
- Use continuous pulse oximetry.
- Use non-opioid analgesics and other comfort measures to help relieve pain. Administer opioids, benzodiazepines and other sedating drugs in limited amounts, titrating carefully and reassessing often. "Zero" pain may be unrealistic.
- For nausea, use ondansetron, not promethazine.
- If oxygen is needed, use judiciously. Oxygen may reduce the respiratory drive and further predispose to apnea.
- Do not use basal rate on IV-PCA for OSA patients
- Keep naloxone immediately available to treat respiratory depression.
- Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea. Anesthesiology, V 104, No 5, May 2006.
- STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea. Anesthesiology, V 108, No 5, May 2008.

Care Management Corner

November and December have been very busy for Care Management.

In Nov., Care Management sponsored a competitive food drive benefiting Central Dallas Ministries. WISH employees earned the top prize of an area lunch with their leadership team. We were able to deliver the food before Thanksgiving. The members of Central Dallas Ministries were so appreciative that we thought of them and their patrons during the busiest time of the year.

In Dec., Cheri Lattimer, executive director of the Case Management Society of America presented the National Transitions of Care Coalition initiative. They are dedicated to improving the quality of care coordination and communication when patients are transferred from one level of care to another.

Our staff celebrated Christmas together at our first annual Christmas Party. Live music was performed by Care Management and other Parkland staff and great food was provided.

We also participated in the Parkland Foundation Toy Drive as well as collecting donations for the Salvation Army for Christmas.

Pharmacy & Therapeutics committee

Tentative date for implementation: Feb. 11, 2009

UAP Continuing Education

This months Continuing Education Program will be on Monday, Jan 5th at 0730, 1000, and 1330 in SR-2 (located in the basement of Parkland Support Services Building B). The one hour presentation will cover Rubella. PCAs, HUCs, CSAs, MAs, Techs, and all others interested are encouraged to attend. Please log on to www.phhstraining.org to reserve your seat.



Duloxetine (Cymbalta®) Indications: depression, neuropathy, fibromyalgia	Remain Nonformulary
Evicel Fibrin Sealant (Human) Indication: Adjunct to hemostasis in surgery when control of bleeding by conventional surgical techniques is ineffective or impractical	Formulary Addition
Ondansetron IV Indications: nausea and vomiting	Restriction Removed (restriction will be removed immediately for IV only)
Promethazine IV Indications: nausea and vomiting	Administration Guidelines Dilute in 10-20 mls of normal saline and push over 10 to 15 minutes. <ul style="list-style-type: none">• A large bore IV should be used (18 gauge or greater)• Should never be given into an IV catheter or a heplock IV but should be given through the IV line instead• Cannot be injected into a hand IV• Should NEVER be given intra-arterial or in a small IV peripheral• If the proper administration and criteria for use of promethazine (Phenergan®) cannot be met, use alternative treatments for nausea and vomiting. Alternatives include IV prochlorperazine (Compazine®) or ondansetron IV.
Romiplostim (Nplate®) Indication: For the treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombo-cytopenic purpura (ITP) who have had an insufficient response to corticosteroids.	Remain Nonformulary

Patient Education Update

Gestures Aid in Learning

Several researchers (A. Adornato, S. Goldin-Meadow, S. Wagner-Cook, to name just a few) have been investigating how gestures impact teaching and learning. While most of the research has looked at learning in children, Adornato has centered on adults. Overall, the research shows that "teacher gesturing improves learning"¹, and newer research now finds that "the gestures students themselves produce have an impact on student learning."¹ Susan Goldin-Meadow suggests why this may happen: "Spontaneous gestures may aid student learning by reducing the amount of memory needed to solve a problem and by providing students with an image, supported by an action, that helps them understand and remember what they've learned."¹ Additionally, her research finds that "the best learners were those students who picked up on the teacher's gestures and used them without being told to."¹ While this is interesting, how can it help you when you teach your patients? If you are a natural gesticulator, feel free to let your hands help tell the story. If your hand movements are restrained, you may choose to work on gesturing more, in order to help your patients achieve better understanding and recall.

If you are a natural gesticulator, feel free to let your hands help tell the story. If your hand movements are restrained, you may choose to work on gesturing more, in order to help your patients achieve better understanding and recall.



References: 1. Students' gestures boost learning. The University of Chicago News Office. Feb. 1, 2006. <http://www-news.uchicago.edu/releases/06/060216.gestures.shtml> 2. Peterson, D. Teaching with Hand Gestures Improves Learning, Especially Foreign Languages. About.com Continuing Education, Deb's Continuing Education Blog. <http://adulted.about.com/b/2008/12/11/teaching-with-hand-gestures-improves-learning-especially-foreign-languages.htm?p=1>.

Update on patient education materials

The Emergency Department, Ambulatory Care Clinic, Intermediate Care Clinic and the East Dallas Health Center have all started using EPIC (our Electronic Medical Record system), and through EPIC are now able to access the patient education materials (also called clinical references) purchased by Parkland from ExitCare. At present, there is no change in the way clinicians in all other areas are getting their patient education materials. In the interests of standardization and keeping materials up-to-date, we are looking into letting all areas have access to ExitCare's materials. Please watch for future updates.

If you already have access to these materials and have found the reading level unsuitable for most of your patients, or have found the materials short of pictures, there is good news; Exit Care is adapting and modifying Parkland patient education materials to their system, and will make these available to us as they are created. Look for these to start appearing by March or April 2009. You'll be able to recognize these materials not just because you'll see the familiar low reading level and clarifying pictures, but also because they will have a 'credit line' across the bottom edge, noting their origin as Parkland materials.

Patient Safety Net (PSN) Reports

An Effective Way to Initiate Change

DO YOU HAVE ANY CONSISTENT FRUSTRATIONS WITH SOME OF THE WAY THINGS ARE DONE AT PARKLAND? Are patients being “touched” by this? Or are you using a lot of time and energy to compensate for how things are done so they don’t touch the patient? WONDERFUL! Those things that just came to mind are what PSN event reports were designed for. We want to identify processes that affect patient safety and satisfaction so that we can make things better for both patients and the staff.

BUT I DON’T KNOW HOW TO PUT IN A PSN. Anyone can enter a PSN by clicking on the PSN “button” on the right side of Parkland’s intranet site, right below the cafeteria menu. If you can read, you can enter a PSN. There is also an easy to understand “how to” simulation at www.uhc.edu. Type in “frontline reporter simulation” in the search box on the site to find it.

WHY BOTHER SINCE NO ONE LOOKS AT THEM ANYWAY? The manager of the event location gets the report. PI/PS Analysts also look at every report and notify other departments who need to know. PI/PS looks for trends to initiate performance improvement projects but some single events have resulted in wonderful process improvements (Have you seen the new automatic openers on CPICU’s front door?).

HOW MUCH DETAIL SHOULD I PUT IN THE SECTION “DESCRIPTION OF EVENT?” More is usually better. Think who, what, where, when, how and why. Stick to the facts. Don’t put personal identifiers in this narrative section (Beginning soon, this information may be shared with other facilities). Use patient, nurse, doctor, etc. Put the names of the staff involved in section “14. Staff Providing Care.” If other patients involved need to be identified, put their name and medical record number in this section as well and add “patient”.

I’M NOT SURE IF I SHOULD PUT ONE IN FOR “THIS” OR NOT. When in doubt, fill it out. You never know who else is having the same issues. Don’t assume they already know. “They” (leadership) may not because no one has told them.

HAVE QUESTIONS OR WANT MORE INFORMATION? Call or email Fay Short, PS/PS analyst at ext. 20659.

Prize Drawing

Respond & You Could Win

The Leadership and Organizational Development team would like to hear from you. Email an example of outstanding leadership at Parkland to clmill@parknet.pmh.org, and your name will be entered into a drawing for several prizes, including a Littman stethoscope, movie passes or gift cards. Responses will be printed in upcoming issues of the *Clinical Care Connection*. Include your name, unit and contact number so we can get your prize to you. Thank you and good luck.

Regulatory Roundup

Services for deaf, hard-of-hearing and speech-impaired citizens

Joint Commission requirement:

The organization respects the patient’s right to understand the information they receive

- The information is tailored to the patient’s age, language and ability to understand
- Provides interpretation and translation services as needed
- Communicates with the patient who has vision, speech, hearing or cognitive impairments in a manner that meets the patient’s needs

American’s with Disabilities requirement:

Health care facilities must provide effective means of communication for patients, family members and hospital visitors who are deaf or hard of hearing.

How we meet these requirements:

Whenever patients, their family members, companions or members of the public are interacting with hospital staff, the hospital is obligated to provide effective communication. Our hospital has sign language interpreters available through Merritt Interpreting Agency at 214.969.5585. This service is available 24 hours per day, seven days per week. In addition, we have TTY phones that can be used by our patients and their loved ones in the hospital. Patient Relations also has volume-controlled hand-sets and hearing amplifiers that can be borrowed for use by your hard-of-hearing inpatients. All of the equipment can be requested for your inpatients by calling Patient Relations at ext. 28945.

Each of the Community Oriented Primary Care health centers also has TTY phones for their deaf patients and their deaf family members or companions to use while in the clinics. In addition, if your site has a high geriatric population, you may request a hearing amplifier from the Geriatric Education Coordinator by calling 214.590.0645. A volume-controlled hand-set would be an inexpensive and useful item for each clinic to purchase for their hard-of-hearing patients and visitors.

Most deaf citizens use a system called Texas Relay to communicate with the hearing world. This organization will communicate to businesses and service providers for deaf clients at no charge. The telephone number from anywhere in Texas is 711. The Deaf Action Center in Dallas is another very good resource for your deaf or hard-of-hearing patients. They can be reached at 214.521.0407.