Clinical Care Connection

Parkland

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

Have you ever thought about teaching nursing school?

UTA is looking for Parkland nurses to serve as clinical instructors in its Initial Licensure BSN Program.

Parkland and the University of Texas at Arlington (UTA) have recently established a partnership to increase clinical placement for nursing students through the 15 month Initial Licensure BSN Program. Visit http://uta.academicpartnerships.com/nursing.asap for more information.

Parkland employees who meet the requirements will receive preferential placement in the Parkland clinical group. If there aren't enough Parkland employees who meet the qualifications to participate, then other nursing students will also be accepted to make the full group of 10 students. These students will complete all the traditional nursing school clinical rotations, but rather than going from hospital to hospital, they will do all of their clinical rotations at Parkland. Their clinical time may also include some off-site rotations to enhance specialties Parkland does not offer or to augment clinical availability.

These students will be in addition to the traditional students UTA already teaches each year. Since there will be more students, more clinical instructors are needed as well. One big difference in this program is that UTA is willing to pay the clinical instructors.

UTA wants Parkland nurses to serve as the clinical instructors for the Parkland clinical group: nurses familiar with the Parkland system, culture and values. Who better to prepare these nursing students to join our ranks as staff nurses than a nurse already dedicated to our patients?

The students will complete their didactic class work on-line on a compressed schedule to accelerate the completion of the clinical portion of the nursing program to 15 months, rather than 24 months. This means their clinical rotations are also compressed over a few weeks rather than one day per week over an entire semester. This is great for clinical instructors because your commitment is for a shorter duration and in your specialty area of practice. You do not commit to a full semester, just to the clinical rotation time frame.

QUALIFICATIONS FOR THE CLINICAL INSTRUCTOR ROLE:

- Current Texas RN licensure
- Master's degree in nursing
- Experience in corresponding nursing area/specialty

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RESPONSIBILITIES INCLUDE:

- Orientation to the role of the clinical instructor
- Direct supervision of the students in the patient care/ facility setting
- Grading clinical assignments (care plans, concept maps)
- Evaluation of student performance
- Providing a professional nursing role model

If you meet the above qualifications and have been waiting for an opportunity to make a contribution to the development of new nurses, as well as grow professionally, send your resume to jboyd@uta.edu with "AP INSTRUCTOR" in the subject line. Be sure to specify your area of expertise in the e-mail. Clinical rotation for the first Parkland group starts in January, so this exciting opportunity is just around the corner. If you have further questions before you apply, e-mail Shirin Pestonjee, Manager of Nursing Education at spesto@parknet.pmh.org.

Performance Improvement

Quality Fair

Over the past few years, departments across Parkland have made unprecedented commitments to quality and safety. Many of these improvement projects have been showcased at the Performance Improvement Quality Fairs held annually in the MacGregor W. Day Auditorium. Past award winners include the Neonatal ICU, PM&R and COPC.

The Performance Improvement department is pleased to announce the winners of the 2009 Performance Improvement Fair held on Sept. 16:

- The technical vote winner was the Glycemic Management Pilot Team for their poster "Glycemic Management Pilot: Coordination of Blood Sugars with Insulin Administration and Meal Delivery." The technical vote is conducted by members of the Quality Improvement Council and considers use of the PDCA cycle and data.
- The popular vote winner was the Parkland Police Department for their poster "Optimizing the Security of Individual's Assets by Reducing Motor Vehicle Burglaries."

Congratulations to all 24 of the poster participants who took time to share their improvement activities.

Med Surg Memos

True or False:

1. The stylet should stay in place after placement of a small bore feeding tube.
2. The PICC line has proximal, medial and distal infusion ports.
3. The infusion hubs should be changed whenever you do a central line dressing change.
4. Nurses are allowed to do a suprapubic catheter exchange.
5. Nurses are allowed to place a TB skin test on other nurses.
6. Any nurse is allowed to read a TB skin test.
7. A patient with a morse fall scale of 40 should never be put on fall protocol.
8. Restraint orders must be renewed every 72 hours.
9. Any nurse may remove a PICC line.
10. An ABG can only be done by a respiratory therapist.

ANSWERS AND RATIONALES:

1. **False** (Procedure #: NSG 30-13). The tube is radiopaque and can be visualized without the stylet.
2. **False.**
   - The colors are only there to help identify each line.
   - EPIC still labels PICCs as proximal, medial and distal. A good way to decide which line can be labeled medial, proximal and distal is by laying the lines out flat on the arm. The Port that is closest to the body is proximal, the middle infusion line can be medial and the line farthest away from the body is distal. This does not mean that they are truly proximal, medial and distal. They all empty at the same place at the end of the PICC.
   - However, the purple color still indicates power PICC. The newer PICCs are now with purple hubs that have "power injectable" written on them.
3. **False** (Procedure #: NSG 18-02). Tubing, extensions sets, stopcocks and clave injection cap shall be changed every 72 hours or with insertion of a new line.
4. **True** (Procedure #: NSG 35-03).
5. **False**. You are only allowed to place a TB skin test on a patient. Only those nurses credentialed by Occupational Health are permitted to place TB skin tests on Parkland staff. You may place a TB Skin test on your patient. You're covered by nature of your nursing license to place a TB skin test.
6. **False.** You must be checked off by Occupational Health to read a TB skin test.
7. **False.** Fall Protocol is a nursing judgment. Even though someone may not score 51 the patient may still be at risk for falls.
8. **False.** Restraints are renewed every 24 hours.
9. **False** (Procedure #: NSG 18-02). A credentialed PICC nurse or the provider is the only person who can remove a PICC line.
10. **False.** All nurses who have gone through general nursing orientation have been checked off to do an arterial blood gas. If you are unsure, see your educator.

Outpatient Observations

Pediatric Assessment in the Outpatient Setting

When beginning your visit, children should be observed visually before touching them. How is the child interacting with you and their environment? Are there any deformities or other concerns that you see? The child should be with their parent or guardian at all times to reduce anxiety, if possible.

Depending on the age of the child it is nice to give them control when you can by offering choices. Maybe you can say, "can I look in your ears or your eyes first?" Use appropriately sized equipment to take vital signs and explain what you are doing while taking their temperature or blood pressure. The range for a normal pediatric patient varies with age.

NORMAL RANGE OF RESTING VALUES (FROM THE NIH WEBSITE)

Age	Weight (kg)*	Pulse (bpm)	Respirations (/min)
Newborn	3.5	100-160	30-60
6 months	7	110-160	24-38
1 year	10	90-150	22-30
3 years	14	80-125	22-30
5 years	18	70-115	20-24
10 years	33	60-100	16-22
12 years	40	60-100	16-22
14 years	50	60-100	14-20

*Weight is the approximate median of boys and girls combined

Blood Pressure - Lower limit of normal for systolic blood pressure is 70 plus two times age in years up to age 10, and is 90 for ages 10 and older.

Developmental Delays - The child should be observed for developmental delays like not walking or talking at an appropriate age. If there are delays they should be referred to appropriate resources for therapy and follow up. For a full list of developmental delays, visit the American Academy of Pediatrics website at www.aap.org.

Child Safety Education - The parents and the child should be educated about child safety concerns like poisons, wearing a helmet, fire prevention, drowning, touching wild animals and other major safety concerns that children encounter.

Parkland Resources:
Dallas Healthy Start: 214.590.1670
Injury Prevention Center of Greater Dallas: 214.590.4455

Positive changes can occure when you tell us about patient safety issues.

Patient Safety & Risk

Code Blue

The Scene: a time in the near future. You're on the elevator when suddenly it starts a non-stop trip to a floor no one selected. Don't be alarmed. You've just become part of assisting with a patient emergency.

Our newly-renovated elevators have a Code Blue function. This allows those with a programmed badge to call the elevator and control it, either to get to a patient during an emergency or to transport a critical/unstable patient.

The elevator doors open and several staff are there with a critical/ unstable patient in a bed waiting for the elevator. Please exit the elevator quickly to make room for the critical/unstable patient and the staff. When the door closes you can call another elevator.

Alternate Scene: The elevator door opens and either a respiratory therapist or nurse is standing there. They say, "I'm on a RAT call." The elevator will deliver them to the floor where the emergency is located. You may stay on the elevator, but when the RAT team staff get off, push the button for the floor you want and the elevator will go back to normal function.

The staff being granted this emergency access (e.g. all the areas that transport critical patients, emergency response teams and security) will receive education on their role soon.

This new process was triggered by a number of PSNs entered by Parkland staff due to long waits for elevators during patient emergencies. Remember, positive changes can occur when you tell us about patient safety issues.

HUC Central

Adapting to change

Sometimes change is as subtle as a gentle breeze. Sometimes change comes down on us like a freight train barreling ahead at full speed. But either way, adaptability is imperative.

The inability to be flexible and accept change can prevent you from reaching your full potential. Try to make informed choices by thinking through situations and avoiding misunderstandings and misinterpretations. Think about the future and ask "what if?" questions. "What can I lose?" "What can be gained?" "How will this change affect me and those closest to me?" Thinking through the possibilities can help you prepare for and accept change. Participate in continual learning and take the initiative to update your knowledge base and skills. This will make you more adaptable. Be open to new challenges. Remember, "what doesn't kill you makes you stronger." Discover and then remind yourself of the positive effects challenges have on your life. Challenges lead to growth, wisdom and the advancement of skills. Look for the silver lining.

Also, know yourself and be truthful to yourself. Have an understanding of your own personal values so the creative solutions you come up with are solutions you are truly happy and comfortable with. Stop clinging to outdated ideas and policies. Remember, change is inevitable. If you can approach change with a positive attitude and creativity you will survive and thrive.

Laboratory Scope

Unannounced Laboratory CAP and AABB Inspections

by Debbie Perrault, Director, Pathology

Every other year the Pathology department has both a College of American Pathologist (CAP) Accreditation Survey and an American Association of Blood Banks (AABB) survey.

The CAP and AABB survey teams are comprised of practicing laboratory professional inspectors. Checklists, which are the same as the Joint Commission chapters and standards, are used by the surveyors as a guide to assess the overall management and operation of the laboratories.

On Sept. 14, two surveyors arrived unannounced to survey Transfusion Services. This was a two day process. Then on Sept. 21, a survey team from the Veterans Administration Greater LA Healthcare System arrived unannounced to survey the rest of the laboratory. This survey team consisted of one leam leader, Dr. Richard Horowitz, and seven experts in each of the laboratory disciplines. During the survey process the inspectors looked at quality control records, proficiency test results, information technology, spent time with the staff, observed work flow and practices, traced specimens through the lab from order to result, visited the floor, observed the process for performing non-waived point of care tests and met with administration.

At the end of the two day surveys, there were two AABB deficiencies, four CAP deficiencies (two of which were corrected on site) and seven recommendations.

To summarize the survey, Dr. Horowitz wrote: "This is a superb laboratory with outstanding leadership, patient-oriented organization and appropriate controls. The laboratory and its leadership are thought of very highly by hospital administration, the medical staff and by nursing-particularly because of the lab's obvious dedication to excellent service, its responsiveness to the needs of the hospital and its patients."

Every employee in Pathology is congratulated for their commitment to the mission of providing excellent care to the patients you have been entrusted with.

Critical Care Vital Signs

Intestinal Ischemia

Intestinal ischemia results from a block in the flow of blood to the intestines. The intestine is highly vascular and ischemia is rare. However, blood can be diverted from the bowel to other organs in times of stress. When the sympathetic nervous system is activated, abdominal blood vessels constrict and peristalsis decreases which can lead to ischemic injury. For example, ischemic colitis resulting from mucosal ischemia caused by decreased blood flow in the bowel is occasionally seen in marathon runners. Other causes of intestinal ischemia are:

- A hernia that becomes trapped or tangled.
- Adhesions in the abdominal cavity.
- An embolus blocking blood flow.
- Arterial thrombus in patients with atherosclerosis.
- Venous thrombus in patients with liver disease, cancer or clotting disorders.
- Hypotension.

Patients with ischemic bowel typically present with pain, nausea/vomiting, diarrhea and/or fever. Other potential findings include large NG output, hypoactive/inactive bowel sounds, abdominal distension and blood in the stool. Diagnostic studies can be done to confirm diagnosis and aid in choosing appropriate treatment. Labs can provide information regarding potential causes. An elevated white blood cell count could indicate a trapped or tangled bowel, necrosis and a possible perforation. Decreased hemoglobin and hematocrit could indicate bleeding which could point to cancer, IBD, clotting disorders or bleeding from another injury leading to hypotension. Decreased sodium, potassium and chloride can indicate issues in the small bowel. Other diagnostic tests that can be performed are guaiac test, x-ray, CT, angiogram, colonoscopy and exploratory laparoscopy.

Treatment for ischemic bowel typically includes surgery, however prompt identification of cause, followed by appropriate treatment can prevent complications and the need for surgery. Treatment can include fluids and electrolytes, blood products, antibiotics and maintaining adequate blood pressure. Patient teaching regarding cessation of smoking, proper nutrition and treatment of underlying disease that increases risk can help prevention of future incidents.

Pharmacy Forum

Decisions from the October 2009 P&T Meeting

CLOPIDOGREL/PROTON PUMP INHIBITOR THERAPY

Statement from Cardiovascular Subcommittee and P&T - The use of proton-pump inhibitors (PPIs) in general should be minimized, whenever possible, in patients who are taking clopidogrel for post-implantation of cardiac stents until more information about the clinical relevance of this interaction is available. In ambulatory patients, there is not enough evidence to support the non-formulary use of pantoprazole instead of the formulary agent esomeprazole in patients receiving clopidogrel post-implantation of cardiac stents.

DOFETILIDE (TIKOSYN™)

Restriction Change - Restricted to order/prescription by cardiology faculty physicians registered with the manufacturer for dofetilide program or Electrophysiology (EP) fellows/ midlevel practitioners under the direct supervision of program registered EP faculty.

For initiation of therapy, the patient must be an inpatient on CCU or 10 West (with continuous cardiac monitoring) for at least the first three days of therapy. Orders during the first three days of therapy must be re-written daily by attending EP faculty or fellow/midlevel and a daily note written by the EP service. The patient's pre-dose and post-dose ECG (with measured QT interval) must be documented with each dose for the first three days of therapy and baseline and daily creatinine clearance must be documented, with dose adjusted as necessary.

For continuation of therapy in a patient admitted to Parkland taking dofetilide prior to admission, the original order on admission must be made by a physician authorized by the manufacturer (or fellow/midlevel under an authorized prescriber's direct supervision) and at least one progress note (or consult note) written by the EP service.

TENECTEPLASE (TNK-ASE™) - Formulary Deletion

PRASUGREL (EFFIENT™) - Remain Nonformulary

DRONEDARONE (MULTAQ™) - Remain Nonformulary

GUIDELINES FOR SEASONAL AND PANDEMIC INFLUENZA 2009-10

Restriction - Treatment with oseltamivir is restricted to patients who are at high risk for complications from the flu who have mild or severe symptoms regardless of the rapid flu test result. High risk groups include:

- Children <2 years old.
- Patients <19 years old on long-term aspirin therapy.
- Adults and children with chronic pulmonary, cardiovascular, hepatic, hematological, neurologic, neuromuscular or metabolic disorders.
- Immunosuppressed adults and children.
- Pregnant women.
- Adults >65 years old.
- Residents of nursing homes or other chronic care facilities.
- Treatment, when indicated, should be started within 48 hours of illness onset. Prophylaxis is restricted to patients at high risk for influenza-related complications who have had close contact with someone likely to be infected or health care workers with direct unprotected exposure to a person with known or suspected influenza.

*Providers will write a note on prescription regarding how the patient meets the high risk category.

INFLUENZA A (H1N1) 2009 MONOVALENT VACCINE - **Formulary Addition** (when supply is available)

SHORTAGE OF VECURONIUM (NORCURON®) - During the shortage Parkland will use Rocuronium (Zemuron®).

DARBEPOETIN (ARANESP®)

Restriction Change*- Refer to Darbepoetin Prescribing Guidelines

Dialysis Patients with Medicare Part B

- Do not dispense outpatient prescriptions for darbepoetin to dialysis patients with Medicare Part B. This should be provided by the dialysis center and billed at the center to Part B.

Outpatient Prescription Requirements at Parkland

New Prescriptions

- Add a requirement baseline ferritin and serum transferrin levels be obtained. The pharmacist will contact the physician if levels have not been ordered, but darbepoetin will not be dispensed.
- Hemoglobin (Hg) value must be obtained seven days prior to initiating darbepoetin. The pharmacist will contact the prescriber if no hemoglobin value is recorded based on the time limits stated above. Darbepoetin will not be dispensed until lab available.

Refill Prescriptions

- Hemoblogin must be obtained 45 days prior to dispensing darbepoetin prescription for refills. The pharmacist will contact the prescriber if no hemoglobin value is recorded based on the time limits stated above. Darbepoetin will not be dispensed until lab available.
- The pharmacist will contact the prescriber if hemoglobin is ≥12 g/dL and there is no new prescription for a lower dosage. Darbepoetin will not be dispensed until new prescription is received.
- Non-responders (non-oncology patients who fail to achieve hemoglobin levels in the 10-12 g/dL range after 12 weeks of treatment with darbepoetin) will be referred back to their prescriber and darbepoetin will not be dispensed.
- Remove existing two refill limitations that are part of the current restriction.

REIMBURSEMENT/FINANCIAL REVIEW OF PRESCRIPTIONS

(for patients using Parkland pharmacies)

- Refer all patients with prescriptions for darbepoetin to a Medication Access Specialist (MAS) for evaluation of Amgen's Aranesp® patient assistance program and Medicare Part D prior authorizations.
- Medicare Part D patients and prescribers must apply for prior authorizations from the Medicare Part D plan.
- The pharmacist may not dispense darbepoetin prescriptions to patients with Medicare Part D on PHP or Ryan White unless they have been denied the prior authorization from their Medicare Part D plan.

The online Parkland Drug Formulary can be found at http://www.crlonline.com
Target date for implementation: Nov. 16
Implementation of Flu Guidelines will take place immediately.

Pharmacy Forum

Darbepoetin Prescribing Guidelines

1. Initiation of erythropoiesis-stimulating agent (ESA) therapy - when to start and laboratory monitoring:

A. Initiation:
- Hemoglobin (Hb) <10 g/dL for oncology patients
- Hemoglobin <11 g/dL for all other patient indications

B. Medical history and physical exam in chart with stool guaiac order if appropriate

C. Labs:
- CBC, reticulocyte count
  - o Within seven days prior to initiating therapy
  - o Within 45 days with refills
  - o Goal Hb range of 11-12 g/dL
- Iron Studies
  - o Within seven days prior to initiating therapy
  - o Serum ferritin (<100 mcg/L Iron indicated)
  - o Serum transferrin saturation (<20 percent Iron indicated)

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2. Dosing*:

- Begin with 0.75 mcg/kg every other week or
- Begin with 0.45 mcg/kg subcutaneously every week
- Round doses to the nearest available package size – (e.g. for an 80 kg patient: 80 kg x 0.45 mcg/kg = 36 mcg. Round to 40 mcg every other week.)

Darbepoetin doses available at Parkland:

25 mcg/0.4mL (0.4 mL syringe)	40 mcg/0.4mL (0.4 mL syringe)
60 mcg/0.3 mL (0.3 mL syringe)	100 mcg/0.5 mL (0.5 mL syringe)
150 mcg/0.3 mL (0.3 mL syringe)	200 mcg/0.4 mL (0.4 mL syringe)
300 mcg/0.6 mL (0.6 mL syringe)	500 mcg/mL (1 mL syringe)

*If the above doses are not prescribed the pharmacist will auto-round.

Darbepoetin should be dosed every two weeks. Depending on starting Hb level, goal Hb may take six to eight weeks or more of dose titration and monitoring to achieve. Monitor the Hb every four weeks once the goal Hb is achieved on a stable dose. Once goal Hb is achieved, the dose should be administered monthly, at double the dose used every two weeks (i.e 40 mcg every two weeks would change to 80 mcg per month in a stable patient).

3. Dose adjustments:

A. If the Hb increases >1 g/dL in any two week period reduce the every two weekly dose by 25 percent.
B. If Hb ≥12 g/dL decrease the darbepoetin dose by 25 percent.
C. If Hb >13 hold the dose and repeat Hb at two week intervals, then restart at previous dose or the next lower prefilled syringe dose (e.g. if patient on 60 mcg q two weeks, try starting at 40 mcg q two weeks).
D. Continue to monitor Hb monthly while on long-term therapy.
E. Iron stores should be repeated every three months.

*It is important to note that most, if not all patients should receive either oral or intravenous iron therapy concomitantly as iron stores will be used up during ESA treatment.

Prescribe iron to accompany darbepoetin unless the patient has documented iron overload syndrome. Iron preparations are OTC and are not covered at Parkland.

Over the counter options include:

- Ferrous sulfate 325 mg one tablet BID.
- Ferrous gluconate 325 mg two tablets BID.
- Ferrous fumarate 90 mg two tablets BID.

IV Iron options include:

- Iron Dextran Complex.
- Ferric Gluconate (restricted).

Dr. Stanley Pomarantz

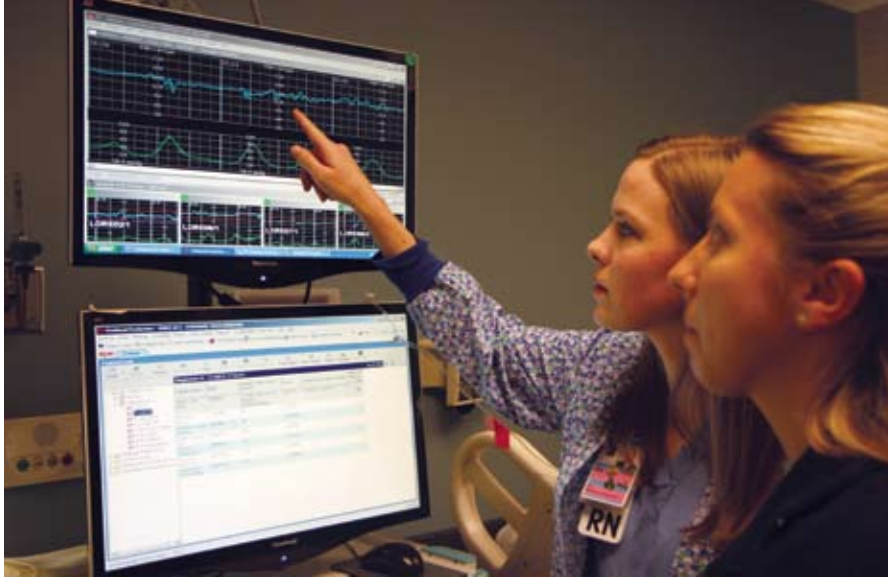
Care Management Corner

New Staff Welcomed to Parkland

Care Management has three new social workers. Latonia Gardner, LMSW is working evening hours replacing David Greene. Monica Wright, LMSW is working part-time and continuing her training toward advanced licensure. Jomeka Downs, LMSW is working part-time and is currently training in the ED.

We would also like to welcome the new Chief Utilization Officer, Dr. Stanley Pomarantz. He comes to Parkland with expansive clinical and managed care experience. He has worked extensively with Medicare and Medicaid as well as commercial insurance programs and will be a great asset to our department as our primary medical reviewer.

Care Management has begun the testing phase of the Milliman Care Guidelines to aid in the appropriate admission and placement of patients while in Parkland. These guidelines will also assist us with discharge planning and in coordinating appropriate transitions in care for our customers. The go-live date is Nov. 30.



Nursing Informatics

Documentation Go-Lives Continue

PeriOp went live with additional EPIC documentation beginning at 12:01 a.m. on Saturday, Oct. 10. They will now be documenting more information from the OR/PACU including fluids and meds given. Some of the IV lines will also be documented. The IP nurses can access this information on the Mar, the Kardex, the OR Summary and the flowsheets.

The next scheduled go-live is the Neonatal ICU on Nov. 9. At that point all documentation in the NNICU, with the exception of nursing assessments and notes, will be done in EPIC. Training for the NNICU nurses will be complete by the first week of November. They have also begun using OBIX to capture fetal monitoring.

The go-live for ICU flowsheet documentation remains scheduled for early December. Documentation of airways for the floors will also begin at that time as well as some EPIC documentation by Respiratory Therapists. E-learning will be available for the IP med/surg staff later in November. Notification will be sent out when it begins.

Remember there is EMR information on the intranet, including support documents for both the nursing and provider staff. If you have questions about EPIC documentation, the answer might be just a click away. Of course your Super Users are always a good source of information.

The Infection Connection

Infection Prevention / Standard Precautions: All Patients. All The Time.

Questions often arise regarding the management of patients who present risks for exposure to disease, but have not been diagnosed. Frequently, the answer is "standard precautions" pending a clinical diagnosis or the results of tests and procedures. This is sometimes followed by a little confusion and, "what does that include?"

The short answer is:

A) Hand hygiene (the foundation of infection prevention).
B) Personal protective equipment (PPE) as appropriate, including gloves, fluid-resistant gowns, masks and eye and face protection.
C) The use of safety needles/sharps and proper disposal.
D) Obtaining and transporting blood specimens per protocol.

Very important: respiratory hygiene/cough etiquette is part of standard precautions. In the midst of the H1N1 pandemic and having entered the seasonal flu season, remember that standard precautions are not discretionary. Observe patients and persons accompanying them. If they have signs of respiratory illness it must be addressed according to protocol. This includes masking, tissues, spatial separation and education regarding hand hygiene and cough etiquette.

See Infection Control Protocol IC3-51. "Guidance for Seasonal and Pandemic Influenza" for complete direction. This can be found at the top of the Spotlight section of the Intranet homepage. Inpatients with the flu must be on droplet and contact isolation. Remember, these targeted isolation categories are in addition to standard precautions.

The standard precautions protocol goes on to describe the proper handling of linens, patient care equipment, crashcarts, leftover supplies and trash/waste disposal. It also addresses the safe preparation of bodies for the morgue.

Disease- specific categories of isolation include contact, contact-d, droplet and airborne. It is your responsibility to be familiar with and follow these protocols. Remember, these are in addition to standard precautions.

In summary, standard precautions are a required group of infection prevention practice. They apply to all patients regardless of suspected or confirmed infectious status. In any setting in which health care is delivered, Infection Control Protocol (IC 2-00) mandates the use of standard precautions to mitigate the transmission of unidentified infections for both patients and health care workers. Assume that every person is potentially infectious or colonized with an organism that could be transmitted to you or by you to someone else. Know them and follow them: all patients, all the time. Be Safe.

Remember: standard precautions for flu season are not discretionary.

The WISH List

REEDA Scoring

All incisions require careful monitoring. REEDA is an acronym used to guide assessment of the episiotomy, cesarean birth incision or tubal ligation incision. REEDA stands for:

R-redness
E-edema
E-ecchymosis
D-drainage
A-approximation

Each item is rated on a scale of 0 to 3. Scores may range from 0 to 15. Average scores per day are:

Day one postpartum	0-6
Day two post partum	0-8
One week postpartum	0-7
Two weeks postpartum	0-1

SCORES ARE DETERMINED UTILIZING THE GRID BELOW:

Points	Redness	Edema	Ecchymosis	Discharge	Approximation
0	none	none	none	none	closed
1	Within 0.25 cm of incision bilaterally	Less than 1 cm from incision	Within 0.25 cm bilaterally or 0.5 cm unilaterally	Serum	Skin separation 3 mm or less
2	Beyond 0.5 cm of incision bilaterally	1-2 cm from incision	0.25-1 cm bilaterally or 0.5-2cm unilaterally	serosanguineous	Skin and subcutaneous fat separation
3	Beyond 0.5 cm of incision bilaterally	Greater than 2 cm from incision	Greater than 1 cm bilaterally or 2 cm unilaterally	Bloody, purulent	Skin and subcutaneous fat and fascial separation
Total					

The REEDA scale may also be used to evaluate the effectiveness of perineal treatments, such as perineal washing (peri bottle),cold packs, sitz baths and topical treatments.

Source: AWHONN Compendium of Postpartum Care

Did You Know?

The Acute Stroke Unit

In October 2008, Parkland was designated a Joint Commission Primary Stroke Center. However there may be some things about the Acute Stroke Unit (ASU), located on 8 West, you did not know.

In 1988, the ASU first opened under the direction of Dr. Ralph Greenlee and Elizabeth "Liz" Callahan, RN. Since that time, the ASU has functioned to care for patients with a primary neurologic diagnosis of stroke requiring a higher level of care such as cardiac, hemodynamic and or neurologic monitoring/management up to the point of mechanical ventilation.

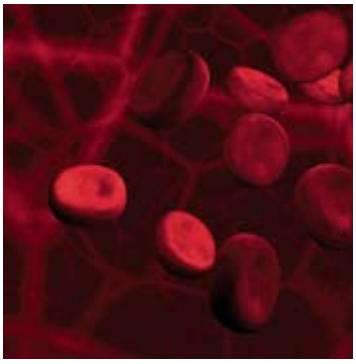
In July of this year, under the direction of Dr. Mark Johnson and Courtnay Bracken Linahan, RN, the ASU has opened an additional three beds. The six monitored beds are staffed by two registered nurses trained in the care of the acute neurologic patient, with a 1:3 nurse patient ratio. Nurses from the ASU accompany their patients with a monitor to all diagnostic and procedure areas. Two beds are due to have video monitoring capabilities in FY 2010, one room can be used for isolation and the unit has been wired for continuous EEG monitoring to transmit to the EEG technicians on the Epilepsy Monitoring Unit.

Unit modalities include: frequent vital signs and neurologic assessment; cardiac, hemodynamic and intracranial pressure (ICP) monitoring; ventriculostomy and lumbar drains; vasoactive drip titration and conscious sedation. While the unit primarily serves the ischemic and hemorrhagic stroke population, patients with poorly controlled seizures, neuromuscular diseases in danger of respiratory failure, a primary neurologic diagnosis or increased intracranial pressure may be admitted to the ASU when beds are available.

And now you know.

UAP Exclusive

Blood: The Necessity of Life



Humans can't live without blood.

The cardiovascular system is comprised of blood, vessels and the heart. These three organs ensure the delivery of oxygen, hormones and nutrients to the organs of the body. This system also removes carbon dioxide and waste products from the cells of organs.

Blood has many functions. It regulates pH, water and temperature in the body and helps protect against microbes and hemorrhage. Blood is typically red in color and thicker than water. The average volume is 4-5 liters for a woman and 5-6 liters for a man. Formed elements or cells compose 45 percent of the volume while the rest (55 percent) of the volume is called plasma.

Cells are divided into three types. Red blood cells or erythrocytes are round biconcave disks that contain hemoglobin. Hemoglobin carries oxygen and carbon dioxide and gives the red cells their color. A typical red blood cell only survives for approximately 120 days. They are produced in the bone marrow of the long bone, hip, vertebra and sternum. The most common condition that involves the red blood cells is anemia, a decrease in the cell's ability to carry oxygen.

White blood cells are the army of the body. There are fewer white cells than red cells but when the body is invaded by a virus or bacteria the white cells increase their numbers to attack the invaders. They also have the ability to move in and out of the bloodstream to seek out the source of infection. A common condition involving white blood cells is leukemia or cancer.

Platelets are the third cell component of blood. Platelets help the blood clot by arriving first at the place a vessel is torn. Thrombocytopenia, or a decreased number of platelets, is a problem seen with platelets.

Plasma is a straw colored fluid that is composed of 90 percent water. It also contains dissolved salts, minerals, antibodies, nutrients, proteins, hormones, waste products and clotting factors.

Patient Education Update

Keep Teaching Your Patients to 'Speak Up'

One of the ways the Joint Commission has tackled health care errors is the "Speak Up" initiative that began in 2002. This program's goal is to help patients become "active, involved and informed" partners in their own health care and to speak up if safe care is not being provided.

This manifests in multiple ways: reminding health care employees to wash their hands, making sure they understand consents, marking the right surgical site and asking about medicines, treatments, research, etc. until they truly understand key factors.

A 2008 survey on the "Speak Up" initiative found that 85 percent of respondents from 1,900 organizations reported that the initiative brought value to their accreditation and certification process. "They also reported that the program has promoted and increased communication with both patients and staff about safety." (The Joint Commission, August 2009). For more information about the "Speak Up" initiative, you can visit http://www.jointcommission.org/PatientSafety/SpeakUp/.

We all want our patients to have safe, healing experiences while in our care. All of us want to deliver care that is free of errors. Be involved in teaching your patients to speak up.

Pharmacy Forum

Adverse Drug Event (ADE) Reporting is Important and Protects Patients

DEFINITION OF AN ADE

An Adverse Drug Event (ADE) is any undesirable or unexpected response to a drug which occurs at doses normally used in humans for the prophylaxis, diagnosis or therapy of disease and requires specific medical intervention.

DID YOU KNOW:

- More than 770,000 people are injured or die each year in hospitals from ADEs.
- ADEs may cost up to $5.6 million per year per hospital (depending on hospital size).
- Patients who experience an ADE on average were hospitalized 8 to 12 days longer than patients who did not suffer an ADE, with hospitalization costing $16,000 to $24,000 more.

TO EASILY REPORT AN ADE:

1. Use the Patient Safety Net (PSN) located on the intranet or contact your pharmacist via pager or the EPIC inbasket.
2. Provide a medic alert bracelet or necklace if necessary.

REQUIRED INFORMATION TO REPORT AN ADE:

- Patient demographics (weight, disease, allergies, etc.)
- Suspect drug(s), doses, duration, start date, stop date, indication
- Reaction(s) to the drug(s)
- Treatment(s) for the ADE
- ADE outcome

Pharmacy Forum

High Alert Medications

Fortunately most medications have a fairly wide safety margin. However there are a relatively small number of medications that have a narrow safety margin and therefore have a higher risk of causing harm when an error involving these high alert medication occurs.

Although errors with high alert medication are no more common than with other drugs, the consequences may be significantly more harmful to the patient. Below are the medications that have been designated as high alert medications at Parkland:

AMBULATORY HIGH ALERT MEDICATIONS

Anticoagulants	Amiodarone	Chemotherapy agents (oral and IV)
Insulin	Narcotic and Opiate	**(NEW)** Vaccines

INPATIENT HIGH ALERT MEDICATIONS

Anticoagulants	Chemotherapy agents (oral and IV)	Insulin
IV Calcium (Chloride and Gluconate salts)	Hypertonic Saline	IV Potassium Salts (Chloride, Phosphates and Acetates)
IV Magnesium Sulfate	Neuromuscular Blocking Agents	All IV Phosphate Salts
Amiodarone	IV Digoxin	IV Dilantin and Fosphenytoin
(NEW) Phenergan IV	Narcotic and Opiate including PCA	**(NEW)** Vaccines

When writing or receiving orders for high alert medications, stop, review and follow any special procedures in place for the medication to improve patient safety.

Pharmacy Forum

Sound Alike Look Alike Drugs

Sound Alike-Look Alike Drugs (SALAD)

Sound alike - look alike drug combinations (SALAD)			Drug Name	Ordering Precautions	Intervention
1	Clonidine	Klonopin	Clonidine, Klonopin	EPIC alert	Shelf talkers, separated from each other in storage areas, Cerner alerts, EPIC alerts
2	Doxorubicin liposomal	Daunorubicin liposomal	Doxorubicin liposomal (DOXIL), Daunorubicin liposomal (DAUNOXOME)	Use pre-printed order form, EPIC Hard Stop, *Tall Man Lettering*	Rx procedures D600-615, Only stored in Pharmacy prior to preparation. Shelf talkers, separated from each other in storage areas, EPIC alerts
3	Ephedrine	Epinephrine	Ephedrine, Epinephrine (ADRENALIN)	Ephedrine restricted to OR use. Anesthesiologist pulls from procedure tray and writes drug name on flow sheet. EPIC Hard Stop, *Tall Man Lettering*	Epinephrine and Ephedrine are to be separated in storage areas, shelf talkers, procurement of Epinephrine ampuls and Ephedrine vials only, EPIC alerts
4	Hydroxyzine	Hydralazine	Hydroxyzine, Hydralazine	EPIC alert, *Tall Man Lettering*	Shelf talkers, separated from each other in storage areas, Cerner alerts, Epic alerts
5	Insulin products		Human insulin glargine (LANTUS) Human insulin (NOVOLIN) 70% ispophane NPH/ 30% regular (NOVOLIN 70/30) Human insulin aspart (NOVOLOG) Human insulin isophane (NOVOLIN N) Human insulin regular (NOVOLIN R) Insulin extended zinc	EPIC alert, *Tall Man Lettering*	Insulins are to be segregated in refrigerated storage areas; In-patient, all patient specific insulin is labeled and segregated in the refrigerator; doses drawn up are double checked before administration. EPIC alerts, Cerner alerts
6	Metformin	Metronidazole	Metformin (GLUCOPHAGE), Metronidazole (FLAGYL)	EPIC alert , *Tall Man Lettering*	Metformin and Metronidazole are to be separated in storage areas, shelf talkers, EPIC alerts, Cerner alerts
7	Concentrated LIQUID morphine products versus morphine solution		10 mg/5ml 500ml bottle 20mg/10ml UD Concentrate: 20mg/ml 30ml bottle, 120 ml bottle	Use Indication Require mg strength for dose Prescriber must specify if concentrated form is desired EPIC alert, *Tall Man Lettering*	The number of available concentrations were reduced with the unit dose cups being used widely in in-patient areas and the concentrated solutions mainly in the out-patient areas. The exception to these are when a non-routine dose is needed, in which case the dose is unit dosed in a syringe specific for that patient's dose.
8	Tramadol	Trazadone	Tramadol (ULTRAM), Trazodone	EPIC alert, *Tall Man Lettering*	Shelf talkers, separated from each other in storage areas, EPIC alerts, Cerner alerts
9	Vinblastine	Vincristine	Vinblastine (VELBAN), Vincristine (ONCOVIN)	Use pre-printed order form which includes trade name EPIC Hard Stop, *Tall Man Lettering*	Rx procedures D600-615, Only stored in Pharmacy prior to preparation. Shelf talkers, separated from each other in storage areas , EPIC alerts
10	Zetia	Zestril	Zetia, Zestril	EPIC alert	Shelf talkers, separated from each other in storage areas, EPIC alerts, Cerner alerts

Parkland

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