

Clinical Care Connection

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

Change Is Coming

Parkland prepares for Electronic Medical Records

The change we are referring to is the electronic medical record (EMR), or as we all affectionately refer to it: EPIC. The go live date is April 27 for Pharmacy and April 28 for other inpatient applications. So the big question is: Are you ready?

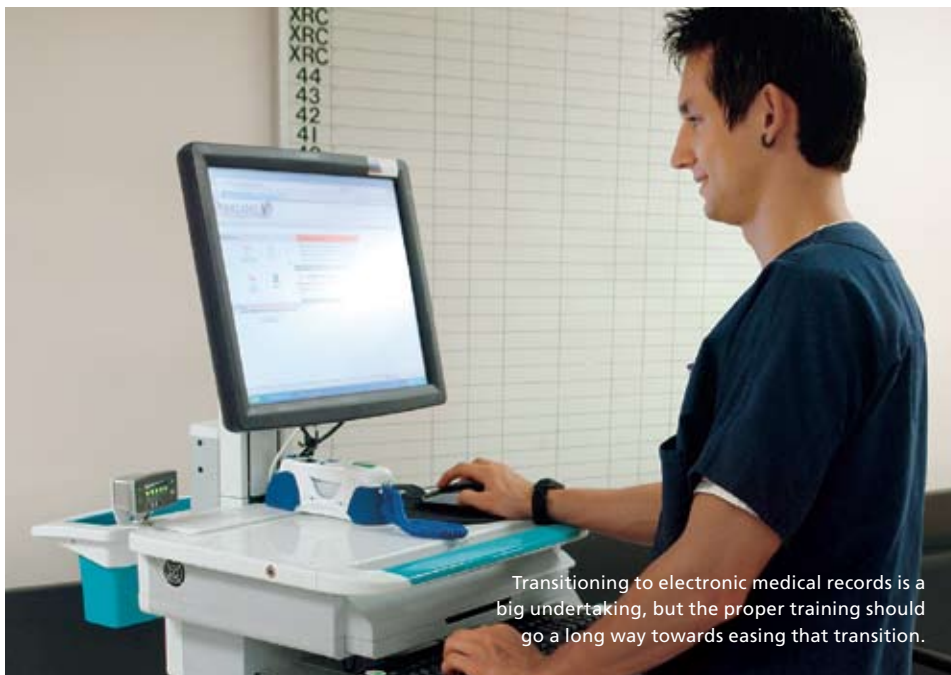
Don't panic if your answer is no. There is still time to get ready and Parkland has resources to help you.

You should be registered for the appropriate EPIC training. If you are not registered and are not aware of the plan for registration, talk to your manager. In an effort to make sure everyone gets registered in the appropriate class, the managers need to register the staff. The nurse educators can assist the nurse managers with registration if needed.

Once you have completed your EPIC training class, you need to go to the EPIC play ground to practice your new skills. Because of the number of employees that must be trained, it isn't possible to train everyone within a few days of go live. Some of you are going to have quite a gap between training and go live. Rather than let this be a time for you to forget all that you learned in class, use this time to become comfortable with these new applications.

Super Users in all clinical areas have been designated by management and will be available

(‘Change’ continued page 2)



Transitioning to electronic medical records is a big undertaking, but the proper training should go a long way towards easing that transition.

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to support the go live. These Super Users will also be available prior to go live to answer questions, support you with your EPIC play ground practice and assist with the classroom training.

Nurse Educators will be trained as end-users to help you in the clinical areas. In the areas that we anticipate the biggest work flow impact, the nurse educators will be providing unit based in-services beginning in March to help you apply your newly acquired EPIC skills to your daily practice. We all recognize that incorporating EMR with your patient care activities will be difficult initially. The nurse educators will try to help you simulate real life scenarios so that you can become more comfortable with the increased use of the computer in your routine work flow. These in-services may not be required in areas where the workflow change isn't as significant during this EPIC implementation (i.e. ICUs). If you think you need additional in-services during March and April, please talk to your educator or manager.

Don't forget that you can and should help each other. Computer skills and therefore, EMR documentation will come more easily to some of you than others. If you are one of the fortunate ones that won't struggle with this transition, take this opportunity to help your colleagues. Remember that at one point you did struggle with something and likely will again.

We will be in a better place as a hospital once we have full EMR. The transition will be difficult, but if we work together, we can make this much less difficult. Remember, our goal is progress without compromising patient care.



Chris Noah helps members of Parkland's Decon Team suit up during a recent disaster drill.

Critical Care Vital Signs

Disaster Dialogue

Contributing Writers Anneka McCallum with Chris Noah, Emergency Management Officer

At the Emergency Nurses Association Conference I recently attended, I heard an inspiring seminar given by some nurses from Hennepin County Medical Center. The nurses who spoke were working in the Emergency Department when the I-35 Bridge collapsed in Minneapolis. They discussed how they handled the influx of patients received after the incident. Both nurses agreed that disaster drills their hospital had been conducting were a substantial help when an actual event occurred.

Their experience showed that diligent preparation and knowledge of policies really helped staff respond quickly in a disaster. The following is an interview with Chris Noah, Emergency Management Officer:

What do you think every staff nurse should know about their role in a disaster?

All staff should know their role in responding to a disaster in the first minutes and hours. They should know who is in their chain of command and how to contact them. Registered Nurses, Patient Care Assistants and Paramedics should be familiar with and understand the IDME triage system (Red, Yellow, Green and Black).

What should staff have prepared before a disaster strikes?

All employees should have a disaster plan in place. The plan should include contact information, means of communication with family and how to provide care for children and pets if the employee has to stay at work or is called in. Staff members should have a disaster kit prepared. Suggestions about what to put in these kits can be found at www.ready.gov. Staff need to know where they should park, to enter through the Employee Entrance. Employees must be wearing their Parkland ID Badge to gain entrance to the hospital.

Can you explain the differences between various types of Code Yellow?

Level I - Regional/State Greater than 24 hrs (the highest level) – All Command Staff are needed, the situation is large or extreme hazards are present

Level II - Community/Regional Less than 24 hrs – All Command Staff are needed, and the situation is short term

Level III - Community/Internal – Situation requires Command Staff but not full activation, such as a 2-5 person decontamination, some computer outages, etc.

Level IV - Normal Operations

What do charge nurses and managers need to know when a Code Yellow is called?

First, a lead person needs to be chosen for communication with the Command Staff during the emergency. The lead person needs to know how and when to quickly move less acute patients to make room for the possible influx of new patients. They also need to know how to request additional resources as necessary.

Charge RNs and those in management positions must complete the ICS 100 and 200 courses by FEMA. See your manager with questions.

PICC Care & Maintenance

PICCs SHOULD BE FLUSHED EVERY SHIFT WHEN NOT IN USE

- Wash hands and wear gloves
- Clean the injection cap with alcohol pad and let dry

Valved Catheter

- Flush with 10cc of NS using “push-pause” technique: quickly starting and stopping injection, repeating in a pulsating method

Non-Valved Catheter

- Inject 2cc of heparin, flush (100units/ml) with a 10cc syringe

DRESSINGS SHOULD BE CHANGED EVERY SEVEN DAYS OR PRN

Supplies

- Central line dressing kit
- Blue clave injection cap
- Securing device
- Additional 2-3 transparent dressings
- Non-sterile gloves
- Alcohol pads

Remove Old Dressing



- Position patient with arm extended and head turned
- Wash hands, put on mask and clean gloves
- Remove dressing, peeling toward the patients head
- Snap open the securing device and lift catheter off posts
- With alcohol, remove the securing device
- Assess the site

Apply Clean Dressing



- Open sterile dressing kit drop in supplies
- Put on sterile gloves
- Cleanse site with chlorhexadine applicator, let dry
- Apply skin prep, let dry
- Place antimicrobial patch around the catheter, slit to the head, blue side up
- Position securing device, peel off the liner and press onto prepped skin
- Attach the PICC line to the posts on the securing device
- Apply transparent dressing, add 2-3 more transparent dressings
- Remove old blue clave injection cap and clean port with alcohol
- Attach new blue clave injection cap
- Date, time and initial the dressing



Shoba Segal

Care Management Corner

Shoba Segal, LCSW, WISH Social Worker II, was presented with the Circles of Life award at the 40th annual Employee Awards Banquet on Feb. 7. Shoba was also named Parkland Employee of the Month for Direct Patient Care in Dec. 2008.

Betty Thomas, LCSW, MSSW, Social Worker II, has been promoted to Social Work Educator and Grants Coordinator for Care Management.

Please be sure to congratulate both of these great employees on their recent honors.

Jail Health staff depend on the Dallas County Sheriff Department's commitment to provide excellent health care. Detention Officers provide escorts for the patients/inmates to the clinic, and they walk the areas with Jail Health staff during the medication pass, nursing rounds and to emergency responses.



Outpatient Observations

A Look Behind Bars

WHAT IS JAIL HEALTH?

The Dallas County Jail is the seventh largest jail in the nation. Inmates are housed in six jails on three different campuses. Each year there are approximately 100,000 inmates taken into the system, 80 percent male and 20 percent female. It is ever-changing with more than 600 inmates "booked-in" or released each day. Of the more than 300 booked in, approximately 120 will have medical problems. The top diagnoses identified are Hypertension, Asthma, chronic pain, drug and alcohol use, Diabetes, seizures and HIV. Approximately 30-40 of these inmates are identified with mental illness.

A typical day for nursing includes a medication pass to approximately 2,800 patients each shift (80-100 patients for each nurse), wound care, vital signs, finger sticks, insulin administration, documentation, transfers and admitting new commits. Performing a simple task is complicated by waiting for an escort or limited access to patients (as they may be in court, in clinic, in the law library, having meal time, visitation or working as a trustee).

Corrections Nurses are first responders to any type of emergency including chest pain, seizures, assaults, suicide attempts, laboring females and cardiac arrests. Corrections Nurses find it helpful to have a varied knowledge base including Med/Surg, OB/GYN, Geriatrics, Mental Health and ER skills, but assessment skills and common sense are a must. Nurses learn to be detectives in their own field of practice in order to obtain accurate information from the patient and to ensure the true problem is identified.

Jail Health staff depend on the Dallas County Sheriff Department's commitment to provide excellent health care. Detention Officers provide escorts for the patients/inmates to the clinic, and they walk the areas with Jail Health staff during the medication pass, nursing rounds and to emergency responses. Staff are chaperoned during any patient contact. While working here everyone works together to ensure that patients are seen and everyone goes home safe.

CHANGES ARE HAPPENING

Many exciting changes and opportunities have taken place over the past year, including a five chair Dialysis Unit, a 12-bed infirmary soon to open, a new jail with increased clinic space and participation in a MRSA research study in conjunction with the University of Chicago.

Beginning March 1, jail health will be taking over the care of the juvenile system in Dallas. They will be working with a new medication delivery system that will be state of the art and one of a kind. Construction of a new Medical Infirmary and a Mental Health Infirmary is scheduled to begin in June. A new electronic medical record is currently being designed with involvement of front line staff in the design phase. Jail Health is indeed a happening place and a place where much is happening.

The WISH List

Female Screening Workshop Coming to Dallas

Professional Education for Prevention and Early Detection (PEPED) at the University of Texas M.D. Anderson Cancer Center in Houston, Texas, was awarded a grant by the Cancer Prevention and Research Institute of Texas (CPRIT). The project is entitled "Female Cancer Screening for Nurses in Rural or Medically Underserved Areas of Texas." We are excited about bringing the workshop to Dallas on March 25-26.

MD Anderson's grant, "Female Cancer Screening Education for Nurses in Rural or Medically Underserved Areas of Texas," is funded by the Cancer Prevention & Research Institute of Texas (CPRIT), formerly the Texas Cancer Council (TCC). Their overall goal is to increase the number of underserved women in Texas who receive cancer screenings, so they have developed a two-day program to teach nurses about prevention, screening and early detection of breast, cervical, ovarian, endometrial, colorectal, lung and skin cancers.

The first day of the program is a classroom day, and the content is very appropriate for a broad spectrum of health professionals (Registered Nurses, Nurse Practitioners, Physician Assistants, Licensed Vocation Nurses, Mammography Technicians, Social Workers, Health Educators, etc).

The second day is a clinical application day for a subset of the participants who attended the first day. Ideally, the two M.D. Anderson instructors would take up to 12 participants (six in the morning and six in the afternoon) into a prearranged clinical setting for three hours to practice doing comprehensive clinical breast exams and discuss appropriate cervical cancer screening and diagnostic management in patient scenarios. These 12 participants need to be Nurse Practitioners/ Physician Assistant – individuals who have been or will be doing face-to-face cancer screening or education with patients.

This event is free for Parkland employees. Log on to www.phhstraining.org to reserve your seat. Contact screme@parknet.pmh.org with any questions.



Notes from Nursing Administration

The Six Essential Elements of Pressure Ulcer Prevention

#1: Conducting a Pressure Ulcer Admission Assessment for all Patients

The first essential element for preventing pressure ulcers is to conduct a pressure ulcer assessment at admission. A pressure ulcer assessment includes both an evaluation of the patient's risk for developing a pressure ulcer and the identification of any existing pressure ulcers.

At Parkland we use the Braden Scale* which assesses sensory perception, moisture, activity, mobility, nutrition, friction and shearing. Assessments are completed within eight hours of admission for all non-obstetrical patients and documented on the appropriate form in the medical record.

If a pressure ulcer is noted on admission, the following actions are initiated:

- Document the location, size and stage**, if known, in the medical record
- Take appropriate nursing action to decrease moisture, friction and shearing and to improve activity, mobility and nutrition
- Notification of the provider that the patient has a "present on admission" pressure ulcer so that the provider may document the ulcer in the medical record
- Request a consult to the Wound and Ostomy Care Nurses
- Enter a report into the Patient Safety Net

NEXT MONTH: Element #2: Reassess Risks for All Patients Daily

* Staging information may be found by reviewing Nursing 27-03, Pressure Ulcers: Assessment, Prevention and Management, Appendix A

** Staging information may be found by reviewing Nursing 27-03, Pressure Ulcers: Assessment, Prevention and Management, Appendix B

A pressure ulcer assessment includes both an evaluation of the patient's risk for developing a pressure ulcer and the identification of any existing pressure ulcers.

Pharmacy & Therapeutics Committee Update

Tentative date of implementation: April 16

Clopidogrel (Plavix®) 300 mg	Formulary Addition
Diphtheria and Tetanus Toxoids, Acellular Pertussis, and Poliovirus Vaccine (Kinrix®)	Formulary Addition for children 4 to 6 years of age
Silver-coated Antimicrobial Dressing (Acticoat®)	Removal of Restriction
Travaprost (Travatan Z®) Autoswitch Travatan to Travatan Z (1:1)	Formulary Addition
Travaprost (Travatan®)	Formulary Deletion

DRUG SHORTAGES – RESTRICTIONS EFFECTIVE IMMEDIATELY

Acyclovir IV

- 1) Pharmacy has quarantined all IV supplies of acyclovir
- 2) A significant portion of supply for Neonatal ICU has been reserved
- 3) Restrict IV acyclovir use in adult patients to ID consult for HSV encephalitis/meningitis and other extreme cases of Varicella Zoster Virus
- 4) Adult alternative agents:
 - a) use oral valacyclovir whenever possible
 - b) when oral therapy is not an option utilize IV ganciclovir as first recommended therapy
 - c) use IV foscarnet as second recommended therapy

Much of our IV acyclovir supply should be restricted to use in the Neonatal ICU where appropriate treatment of HSV encephalitis/meningitis in neonates is crucial to preventing or at least limiting brain damage and saving the child’s life as both HSV1 and HSV2 encephalitis/meningitis carry significant mortality risk. Adult patients have other viable alternatives. All use of acyclovir in adults will be on a case by case basis for use where ID has recommended its use and the ID pharmacist approves use (Anita Rahman and Cindy Zoellner).

Aztreonam (Azactam®)

Restricted to Infectious Diseases Attending Faculty and Fellows. Recommend Allergy and Immunology Consult to evaluate patient allergy for alternative therapies and/or desensitization.

**Once constant supply is available the above restriction will be removed.*

Studies have found after three days of continuous use, fentanyl patches may still contain drug with enough residual drug to cause harm.

Safe Use of Fentanyl Patches

The fentanyl patch is used to provide continuous opioid pain killer for 72 hours, after which it should be removed and replaced with a new patch. Studies have found after three days of continuous use, fentanyl patches may still contain enough residual drug to cause harm. Therefore, the appropriate disposal of used and unused patches is imperative.

Fentanyl patches should be folded in half so the adhesive backing is folded together and adheres to itself. The patch should then be disposed of in a sharps container. Given the environmental concerns patches should not be flushed down the toilet.

The product monograph indicates that the gel from the drug reservoir must not touch the skin; if it does, the skin must be flushed with water. Soap, alcohol and other solvents MUST NOT be used to remove the gel as this increases the drug’s ability to penetrate the skin. Gloves should be worn when handling the patch.

Performance Improvement & Patient Safety Stories

Failure Mode Effects Analysis for 2008: Heparin Use in the NNICU

Each year, The Joint Commission requires hospitals to complete a Failure Mode Effects Analysis, or FMEA. Teams use FMEA to evaluate processes for possible failures and to prevent these failures by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis on prevention may reduce harm to both patients and staff. The 2008 Parkland FMEA process began in Oct. 2007 and the team followed several steps:

Step One: Select a process to evaluate with FMEA

After reading and hearing about the heparin medication errors and the newborn twins of Dennis Quaid in a neonatal ICU in California, we decided to complete our 2008 FMEA by reviewing the use of heparin in the Neonatal ICU (NNICU) at Parkland. Heparin is a powerful anticoagulant, or "blood thinner", and can cause bleeding and/or hemorrhaging if the dose is not carefully managed. In the Parkland Neonatal ICU, as in many NNICUs, heparin is used in IV fluids and IV flush to keep the IV catheters open.

Step Two: Recruit a multidisciplinary team

Our team consisted of NNICU Nursing staff, NNICU Medical staff and Pharmacy. Two Project Managers from Performance Improvement & Patient Safety led the team through the FMEA process.

Step Three: Have the team meet together to list all of the steps in the process

The team listed and reviewed all steps in the processes related to heparin in the NNICU.

Step Four: Have the team list failure modes and causes

The team then listed and reviewed all possible "failure modes"- anything that can go wrong, no matter how minor or rare. Then, for each failure mode listed, the team identified all possible causes.

Step Five: For each failure mode, have the team assigned a Risk Priority Number, or RPN, for the likelihood of occurrence, likelihood of detection, and severity and then evaluate the results and use the RPNs to plan improvements.

The team created an action plan that included:

- Removing look-alike vials of heparin
- Removing all but one concentration of heparin from the NNICU PYXIS
- Removing the heparin from all non-central line flush
- Decreasing the concentration of heparin flush used for central lines
- Removing heparin from flush used for lines with continuously running fluids

The team's work concluded in Nov. 2008, but the success of these changes will be continuously monitored through PSN reports and Pharmacy drug use reports.

If you would like more information regarding the FMEA process, please contact Georgia VanderBoegh, Senior Project Manager in the Performance Improvement & Patient Safety Department at ext. 28373.



The new automated testing platform will provide Lab Central the capability to more consistently meet TAT expectations, standardize and simplify processes as well as reduce employee stress.



Roche COBAS 6000 analyzers are already in the lab, with front end automation scheduled for March.

Laboratory Scope

Lab Central Automation Project Update

In the past several months, there have been numerous changes to Lab Central's layout to accommodate an automated front end accessioning/processing unit operating in conjunction with the Roche COBAS 6000 automated testing platform for general chemistry and immunoassay tests.

The preparation steps, started in late 2007, have involved a LEAN project to streamline processes, removal of permanent counters, knocking out existing walls, creating a new specimen drop off space and door capacity, drilling new drains, re-designing existing testing areas with modular furniture, placement of the new analyzers, training staff and testing the IT changes and additions.

The first phase of the analyzer implementation was completed in Dec. 2008 with the go live of the drugs of abuse testing on Dec. 17. Transitioning the remaining 150 assays from five different analyzers to one testing platform is ongoing. Correlation data between test results on the current instruments vs. the new Roche COBAS 6000 will assure no disruption in the current level of service and in some instances, augmentation of test menu or availability.

The new automated testing platform will provide Lab Central the capability to more consistently meet TAT expectations, standardize and simplify processes as well as reduce employee stress. Completion of this phase of the project is expected by the end of first quarter of 2009.

In phase two, the automated front end unit will handle some of the accessioning and processing via an automated track system, barcode scanners, automated centrifuges for blood specimen spinning, an automated aliquoter as well as transport the specimens to the COBAS 6000 analyzers. The connection of this unit to the analyzers will complete the track circuit for this automation line in Lab Central. This unit is scheduled to be delivered in March with expected go live by late spring 2009.

Communication memos and e-mails will soon be sent to inform the Pathology clients of minor changes in some tube requirements and several other changes to our test menu. We are excited about our process changes and continuing to provide you with the highest quality laboratory services.

UAP Exclusive

Rubeola

Rubeola is a very contagious viral infection. It is known by many names such as the hard measles, red measles, eight day measles and morbilli. Prior to 1963 over 500,000 cases per year were reported in the United States. Over the last 50 years the number of cases has declined significantly to less than 200 in the last eight years due to the development of a vaccine. The majority of cases diagnosed in the United States occur in unvaccinated children and adults or adults travelling into the United States from a foreign country. Rubeola is still a common infection in other parts of the world where vaccination is unavailable.

Transmission only occurs through humans by means of droplet emission during coughing or sneezing. The virus can remain in the air for up to two hours. Signs and symptoms begin 10-12 days after exposure, after the virus has grown in the lymph nodes surrounding the airway passages. Typical initial symptoms are cough, running nose and conjunctivitis (red eyes), which then progresses to a high fever (>104° F). After two to four days Koplik's spots, small red spots with a white center, appear inside the cheeks by the molars. A rash appears on day four or five starting at the forehead and travelling downward toward the arms and legs lasting five to six days. Thirty percent of cases can develop complications of ear infections, croup, diarrhea, pneumonia (children), encephalitis (adults) or death.

Even though there is no specific medical treatment for rubeola, physician should be contacted immediately, especially if the individual is an infant, has tuberculosis or has any treatment or medical condition that results in a depressed immune system. Lifetime immunity occurs after a case of measles. It is recommended that all children receive a vaccination at the age of 12-15 months then repeated at age 4-5. Vaccination is 95 percent effective for immunity.



The Infection Connection

Standard Precautions

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin and mucous membranes may contain infectious agents. Failure to follow standard precautions poses a serious and unnecessary risk to personnel and patients. The goal is to dramatically reduce exposures to bloodborne pathogens and respiratory infections such as tuberculosis.

These precautions apply to all patients, regardless of suspected or confirmed infection, in any health care setting. Elements include hand hygiene and the use of personal protective equipment (PPE) such as gloves, gowns, masks or facial protection, depending on the anticipated exposure. Equipment or items likely to have been contaminated must be cleaned and disinfected. Safe use and disposal of sharps is important. Hand hygiene and cleaning of equipment also protect patients.

Respiratory Hygiene is a strategy to prevent transmission from persons with undiagnosed respiratory infections. This applies to anyone with signs of illness that include cough, congestion, rhinorrhea or increased production of respiratory secretions. The elements include: posted signs in appropriate languages with instructions to patients and visitors, source control measures (e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person) and hand hygiene after contact with respiratory secretions. Isolation precautions are required when certain infections such as influenza or tuberculosis are suspected.

Please review changes in protocol IC2-00 available on the intranet for specifics or contact the Infection Control Department with questions at ext. 28127.

Failure to follow standard precautions poses a serious and unnecessary risk to personnel and patients.



Proper documentation is not only required, it's in the best interest of our patients.

Regulatory

Documentation of Adverse Events

Appropriate documentation by health care providers promotes quality of care, preserves the financial integrity of the organization and is required to support regulatory compliance. The Centers for Medicare and Medicaid Services (CMS) requires documentation in the medical record when a patient experiences complications or unexpected outcomes.

How should these types of events be documented? Here are some general Do's and Don'ts:

DO	DON'T
document facts, observations, patient condition and complications	exclude to document an adverse or unexpected event – it could be perceived as “willful concealment”
be accurate – use clear concise language	make subjective statements or use vague or ambiguous subjective terms
chart anything unusual or unexpected	document that an incident report was completed, or refer to risk management, quality assurance, or peer review activities or meetings
avoid accusatory language	criticize another practitioner's judgement or recommendations
document relevant conversations with patient and family and their response when an adverse event occurs	document hearsay comments as if they were fact. Instead, document the source of the comments and document the actual statement in quotation marks

If you have any questions or would like more information, contact Risk Management at either ext. 20195, 20651 or by leaving a message on the Risk Hotline at 24000.

Patient Education Update

Patient Education is a Professional Responsibility

The Joint Commission has standards regarding patient education, but have you ever wondered what they actually have to say about this important patient right and professional responsibility?

In their own words ...

Introduction to Standard PC.02.03.01:

Chronic disease is on the rise, and patients are becoming increasingly responsible for managing their own health at home. Acute care patients are often discharged or released from health care settings with instructions for self-care that can range from changing bandages to caring for drains to home infusion. As a consequence, patient education continues to take on greater importance in influencing the patient's outcome and in promoting healthy behaviors. To equip the patient to provide for his or her health care needs, the organization needs to assess the patient's learning needs and use methods of education and instruction that are matched to the patient's level of understanding.

Elements of Performance

- The hospital performs a learning needs assessment for each patient, which includes the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations and barriers to communication
- The hospital provides education and training to the patient based on his or her assessed needs
- The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment and services

- Based on the patient’s condition and assessed needs, the education and training provided to the patient by the hospital include any of the following:
 - An explanation of the plan for care, treatment and services
 - Basic health practices and safety
 - Information on the safe and effective use of medications
 - Nutrition interventions (for example, supplements) and modified diets
 - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
 - Information on oral health
 - Information on the safe and effective use of medical equipment or supplies provided by the hospital
 - Habilitation or rehabilitation techniques to help the patient reach maximum independence
- The hospital evaluates the patient’s understanding of the education and training it provided.

Safety Stop

Preventing Needlesticks

A leading cause of Parklands employee workplace injuries are needlesticks. To reduce employee injury risks:

- Use needles with safety devices when available
- Familiarize yourself with the SHARP products before you use them. If a safety product is used, always use it correctly and consistently to avoid a needlestick injury
- Always wear properly fitting personal protective equipment – gloves, eye protection, etc.
- Never reach into trash cans, basins or other containers with your hands. You never know when there might be a hidden needle
- Be extra careful during emergent situations. Always keep exposed needles pointed down and away from you and others. Alert co-workers when you have a needle or sharp in your hand
- ALWAYS be considerate of others. Dispose of all used needles and sharps in the appropriate containers
- Expect the unexpected. Have an adequate number of supplies readily available for the procedure and ask for help from a co-worker if necessary
- Never place trash against your body to compress or secure it
- Avoid recapping needles
- If injured by a needle, immediately wash the area with soap and water
- Immediately report all needlesticks and complete an Injury On Duty/Occupational Exposure Report. Call Occupational Health at ext. 21234 and HR/Workers Compensation by fax at ex. 22715 within 24 hours.

See Parkland Policy 10-14, Injury On Duty/Occupational Exposure for more information.

There are simple precautions you can take to help prevent needlesticks at Parkland.





With the continued nursing shortage and the evolving role of nurses within the labor force, employee satisfaction will continue to be a focus in the recruitment and retention of high quality staff members.

Leadership Lingo

Empowering Frontline Staff: More Than a Human Resources Gain

As nurse leaders, we all know how much of an impact employee satisfaction plays in recruitment and retention of quality nursing staff. With the continued nursing shortage and the evolving role of nurses within the labor force, employee satisfaction will continue to be a focus in the recruitment and retention of high quality staff members. More and more, nursing literature discusses nursing satisfaction in relation to improving retention, patient outcomes and patient satisfaction. Researchers continue to publish studies investigating methods to engage employees, create a positive work culture and improve communication between frontline staff and administration. Many studies have found facilities providing greater empowerment and autonomy to frontline nursing staff have benefitted beyond initial recruitment and retention objectives.

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), developed the Magnet Recognition Program for health care institutions based on research through the nursing shortages incurred through the 1970s and 1980s. Resulting from these studies, fourteen "Forces

of Magnetism" were identified as characteristics of institutions with successful nurse recruitment and retention. Autonomy, personal development, professional models of care and resources are characteristics nurse leaders, at any level, can have an impact on. Some of the means to assist in attaining these forces are: establishment of unit nursing councils to discuss unit based issues and performance improvement needs, incorporation of staff level nurses into hospital committees and seeking bedside nurses' input regarding policy and procedure development or revision.

While implementing the latter two means may not be feasible for various reasons, establishment of unit councils provides staff the autonomy to impact work culture, satisfaction and clinical practice at the unit level. A unit council focuses on specific issues such as unit policy and procedure, staff recognition and performance improvement. These councils have been instrumental in developing, testing and analyzing pilot studies, which have gone on to impact organizational performance improvement. Some areas where unit councils have been instrumental in impacting positive changes are workflow, product evaluation and institutional standards of care, such as ventilator associated pneumonia (VAP), sepsis, emergent situation response and unit orientation processes. By supporting a unit level approach to performance improvement, nursing leadership can enhance frontline staff members' perception regarding decision making, organizational involvement, communication with leadership, recognition and organizational commitment to the wellbeing of its patients and employees.

Unit councils serve as a valuable resource for identifying practice issues, developing effective change implementation strategies and monitoring unit level compliance. Ultimately, providing a greater level of empowerment and autonomy to frontline staff can benefit an organization by optimizing patient outcomes, organizational culture and cost effectiveness.

Bed & Skin Inservice Fair

Make plans to attend the Bed & Skin Inservice Fair. It will be 12:30 p.m. - 6:30 p.m. March 20 and 6 - 9:30 a.m., 11 a.m. - 2 p.m. and 3 - 6:30 p.m. on March 23 and 24, all in the Ron J. Anderson, MD Conference Center. KCI and Convatec will be in attendance and no pre-registration is needed. For more information, contact Venita Dasch at ext. 25847, Tammy Brake, RN III in SICU at ext. 26100 or Sahar Seyedkala at ext. 28554.