



Physical Therapy Department Launches Jet Lavage and Mist Therapy

Submitted by:
Sanpri Purdy-Porter, PT

The Carolina Specialty Hospital Physical Therapy department is taking part in the advancement of wound healing with the introduction of jet lavage and mist therapy for certain stage III and IV wounds. We are currently participating in a trial of these therapies to determine which services will best work with our patient population. Jet lavage (also known as pulse wound irrigation or pulse lavage) has been utilized for years by physical therapists as an adjunct to standard wound care. Jet lavage aides in the debridement of nonviable tissue and increases circulation to the wound itself in order to allow faster healing. This system consists of a hand piece or "gun" attached to suction and an irrigant (most often saline solution) which is applied directly to the wound. Some advantages of this wound care system include:

1. It provides site-specific treatment without damaging surrounding healthy tissue
2. It is able to come in contact with difficult-to-access wounds (such as those with tunneling) by using special suction tips.
3. It is portable and patient

specific, which is very useful for our patient population, given patients' medical acuity and exposure to multiple microorganisms. Certain parts of the system are designated for multiple use for one patient, limiting cross-contamination.



Mist therapy with ultrasound is also a portable wound care system which utilizes a hand held wand attached to an ultrasound machine that dispenses a low frequency ultrasound and saline mist. The therapist manually moves the wand several times across the wound for a specifically calculated amount of time in order to allow penetration of the ultrasound waves, which has been known to reach depths of 3.5 mm below the tissue surface. This property allows cell regeneration to hasten. Some additional

benefits of mist therapy include:

1. It helps in the reduction of bacteria, including VRE, MRSA, and pseudomonas
2. It increases blood flow to the wound for healing
3. It is relatively painless.
4. It may allow for a low level debridement of the wound.

Since the physical therapy team began the use of jet lavage for a select few patients, we've observed positive responses in the reduction of nonviable tissue (i.e. yellow slough) in wound beds. We recently began mist therapy July 11, 2011 and anticipate measurable results from this treatment as well. Both jet lavage and mist therapy can be used prior to the application of wet to dry dressings and negative pressure wound therapy. It is our hope that by using these systems we can increase the rate at which some of the more involved wounds heal, thereby reducing length of stay for these patients.

(Sources: Celleration Mist Ultrasound Healing Therapy, Simpulse Varicare Pulsed Lavage with suction, Wound Healing Alternatives in Management, 3rd Edition, Luther Kloth/Joseph McCulloch, 2002)

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From the desk of the CEO

Fiscal Year 2012 is coming. Although we are still in calendar year 2011 (for many more months) our fiscal year will end July 31, 2011. It would be an understatement if I said we went through a great deal of changes during this fiscal year. These changes included: changes in CEO, changes in doctors, to changes in processes and a lot of new faces throughout our hospital family. Change is often looked upon as difficult and stressful and I know when everyone was going through all of these changes it was extremely difficult and very stressful. But you know what? We made it through. Top quality care was provided and patients were cared for by the talented hands, gifted minds and passionate hearts of all of our staff. 2010 may be looked back upon as the beginning of our future success. I learned a long time ago that in order for us to enjoy and appreciate the sunshine, we must experience some rain (OK, maybe 2010 was a thunderstorm or maybe even a tornado – but you get my point).

So let's get excited for Fiscal Year 2012!

Dan

Introducing Neal Alexander, Governing Board Member

Neal Alexander has been a member of the Governing Board of Directors since October 2003. He serves as chair of the Human Resources Committee and on the Finance Committee. Neal retired March 31st after forty three years of service with Duke Energy Corporation where he was Vice President Human Resources for the Franchised Electric and Gas Group. In his retirement he plans to continue his church community work, enjoy time at the beach and spend time with his family. Neal is married to Shirley and they have two daughters and two grandchildren.



Tips on Managing the Heat

The risk of heat exhaustion and heat stroke rises along with the temperature and humidity. Heat illnesses occur when the body's cooling mechanism becomes overloaded. When the heat starts to rise - slow down. Regardless of your activity level, drink more fluids - your body needs water to prevent dehydration during warm summer days. Stay away from liquids that contain caffeine, alcohol, or large amounts of sugar. Stay indoors or in shaded locations; wear lightweight, light-colored, loose-fitting clothing; and limit your outdoor activity to morning or evening hours when it is cooler outside.

Signals of Heat Emergencies

Heat exhaustion is a milder form of heat-related illness that can develop well after dehydration occurs. Those most prone to heat exhaustion include the elderly, those with high blood pressure, and children. Some symptoms of heat exhaustion include: cool, moist, pale or flushed skin; muscle cramps; heavy perspiring; nausea and sometimes vomiting; weakness; dizziness; dry mouth; and a headache.

Heat stroke is a life-threatening situation. It occurs when the body is unable to regulate its temperature. Heat stroke can occur within 10-15 minutes of the first symptoms. Signs of heat stroke include: very high body temperature (above 103 degrees); hot, dry, red skin; no sweating; nausea; dizziness; confusion, disorientation, hallucinations; or loss of consciousness.

Treatment of Heat Emergencies

If you feel you are suffering from heat exhaustion, it is important to get out of the sun and into a cool place; loosen clothing; drink water/fluids (be sure to avoid caffeine and alcoholic beverages);

take a cool shower, bath or sponge bath; and rest.

Heat Stroke is a medical emergency - have someone call for immediate medical assistance while you begin cooling the victim. Get the person to a shaded area; cool him/her rapidly using whatever methods you can (immerse in a tub of cool water, place in a cold shower, spray with cool water from a garden hose); do not give fluids; if convulsions occur, keep the victim from injuring himself; call the hospital emergency room for further instructions if medical assistance is delayed in responding.



Healthy Swimming

Summer time means fun in the sun, and plenty of fun and games in the water - but did you know that germs could contaminate swimming water? Recreational water illnesses (RWIs) are spread by swimming in contaminated recreational waters such as: pools, water parks, lakes, and the ocean. Germs causing RWIs can be killed by chlorine, but it doesn't work right away. It takes time to kill germs, and some are resistant to chlorine and can live in pools for days. Here are some tips on how to protect yourself and your family from RWIs.

Swimmer's Ear

"Swimmer's Ear" is an infection of the ear and/or outer ear canal, which can cause the ear to itch or become red and inflamed. More common in children and young adults, movement or touching the ear can be extremely painful. Reduce your risk of getting Swimmer's Ear:

- Dry your ears after swimming.
- Check with the pool staff about the chlorine and pH-testing program at the pool. Those with good control are unlikely to spread Swimmer's Ear.
- Avoid swimming in locations that may have been closed because of pollution.
- Avoid putting objects (e.g. fingers, cotton swabs) in your ear that may scratch the ear canal and provide a site for infection

Cooking Outdoors

No matter what time of the year, more and more people are cooking outdoors. But outdoor cooking during the summer seems to pose a few extra challenges - leaving food out for just a short period of time under the hot sun can result in harmful bacteria rapidly multiplying and it increases the chance of getting foodborne illness. Here are some basic guidelines for safe food handling during the hot summer months:



(continued on page 7)

Happy Anniversary CSH Team!



May—July

One Year

Aieral Johnson-Gordon
Connie Miller
Julie Feis
Tre Robinson
Karen Market
Traci McSwain
Cheryl Uttley
Janine Owens
Blake Holl
Brandi Dillingham
Brian Stroman

Two Years

Darice Miller-Davis
Diana Rowe
Aimee Lamb
Doug Gallagher
Sandy Louissaint
Harun Jelin
Selwyn Wishnefsky

Benjamin Wuor
Mirtha Babcock
Calida Ramsey
Carmita Edison

Three Years

Dana Clifton
Linda Lynch
Drenna Hannon
Portia Davidson

Four Years

Mark Tetteh-Ocloo

Five Years

Kohe Lombadu
Jan Plyler

Six Years

Sandra Sumler
Kerrie Burns
Jeff Ware

Eight Years

David Bowers

Thank you for your years of hard work and dedication.

New Employees

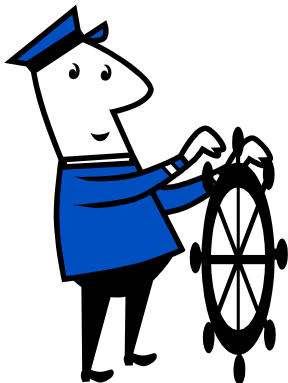
May—July

Atia Liaghat
Rachel Williams
Pat Hendrix
Regina Sifford
Alyssa Johnson
Ty Easton-Mervin
Michael Scanlon
Andrea Brown
Frederick Crosby
Kayla Jackson
Rose Faulhaber

Welcome to those of you new to our team!

Sailing Towards Accreditation

by Teshia Davis, DCS



Yes, it is that time again!

Carolinas Specialty Hospital will be setting sail towards Joint Commission Accreditation. Yes, it

has been nearly three years' since our last accreditation survey! We expect our survey in November 2011, although it could be sooner.

The Joint Commission kickoff will set sail on July 25, 2011 with Joint Commission Team Trivia!

1. Form your team of NO MORE THAN 5 PERSONS TO A GROUP.
2. Name your group.
3. Turn in your groups' name and team members to Teshia Davis by July 25, 2011.

4. Pick up your Joint Commission Guide at the kick off on Monday July 25, 2011.
5. Play Team Trivia. ONLY one answer per group.
6. There will be one group winner per week.
7. There will be ONE group winner at the end of the contest.

Trivia will be displayed on the bulletin board near the case management office.

Have fun!

Happy Birthday to You!

<u>September</u>				<u>October</u>			
Elvira Cornelius	9/1	Julia Wright	9/13	Kionne McKelver	10/1	Ann Marie Nawn	10/20
Linda Lynch	9/2	Catherine Crawford	9/14	Lawrence Martin	10/2	Amy Godwin	10/21
Valerie Warren	9/3	Shelia Bost	9/20	Debra Sanders	10/7	Melissa Wood	10/22
Tanya Alexander	9/3	Hubert Middleton	9/21	LaTasha Colter	10/15	Julie Feis	10/23
Brian Goode	9/6	Sandra Sumler	9/27	Doug Gallagher	10/20	Whitney Ronan	10/29
Wanda Hudnall	9/9	Brandi Dillingham	9/27				
<u>November</u>				<u>December</u>			
David Bowers	11/8	Portia Davidson	11/13	Gerturde Nelson	12/4	Valerie Washington	12/13
Georgette Cameron	11/8	Brian Stroman	11/14	Melissa Tyo	12/4	Elvis Velic	12/14
Shawna Coye	11/8	Noreen Kipp	11/17	Jan Plyler	12/9	Carmita Edison	12/14
Cheryl Hendren	11/9	Rose Faulhaber	11/23	Julius Hobbs	12/9	Georgia Hansen	12/16
Regina Sifford	11/9	Frederick Crosby	11/26	Dana Martin	12/9	Montoya Regan	12/17
Jarisa Neal	11/10	Traci McSwain	11/28	Anne Boatenreiter	12/10	Nine Wilson	12/21
				Ellen Anin	12/10	Pat Adeigbo	12/26
				Crystal Pamilton	12/12	Mimi Wubeshet	12/26
				Jessica Robinson	12/12	Dionne Tindall	12/27
						Sandy Louissaint	12/31

ICD-10-CM Is Coming, But What Is It? submitted by Andrea Webb, HIM

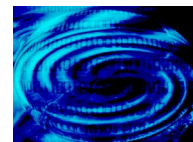
ICD-10-CM is a clinical modification of the World Health Organization's ICD-10, which consists of a diagnostic classification system. ICD-10-CM includes the level of detail needed for morbidity classification and diagnostic specificity in the United States. It also provides code titles and language that complement accepted clinical practice in the U.S. As with ICD-9-CM, ICD-10-CM is maintained by the U.S. National Center for Health Statistics.

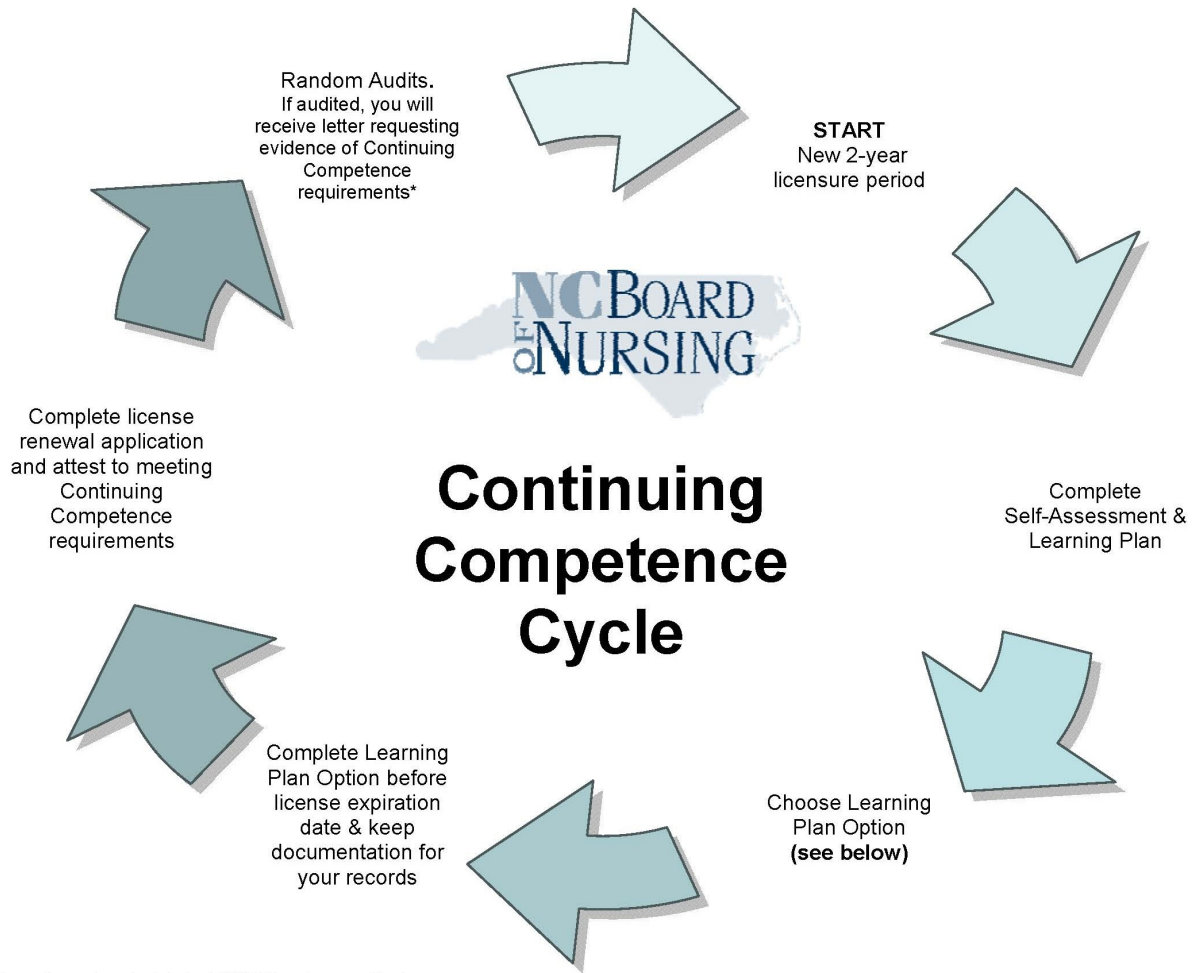
When the US modified ICD-9 to create ICD-9-CM more than 30 years ago, a third volume was added to

capture procedure codes. However, instead of appending a short volume to ICD-10-CM, a complete classification, ICD-10-PCS, was developed. This procedural coding system is much more detailed and specific than the short volume of procedure codes included in ICD-9-CM.

The ICD-10-CM system consists of more than 68,000 diagnosis codes, compared to approximately 13,000 ICD-9-CM diagnosis codes. ICD-10-PCS consists of 87,000 procedure codes. Together the ICD-10-CM and

ICD-10-PCS codes have the potential to reveal more about quality of care, so that data can be used in a more meaningful way to better understand complications, better design clinically robust algorithms, and better track the outcomes of care. ICD-10-CM and PCS incorporate greater specificity and clinical detail to provide information for clinical decision making and outcomes research.





*Do not send materials to NC BON unless audited

LEARNING PLAN OPTIONS							
Select one of the Learning Plan Options							
1) National certification or re-certification by a national credentialing body recognized by the Board	2) 30 contact hours of continued education	3) Completion of a Board approved refresher course	4) Completion of a minimum of two semester hours of post-licensure academic education related to nursing practice	15 contact hours along with one of the following options (5-8):			
				5) completion of a nursing project as principal investigator or co-investigator to include statement of problem, project objectives, methods, date of completion and summary of findings	6) authoring or co-authoring a nursing-related article, paper, book or book chapter	7) developing and conducting a nursing continuing education presentation or presentations totaling a minimum of five contact hours, including program brochure or course syllabi, objectives, date and location of presentation, and approximate number of attendees	8) 640 hours of active practice within previous 2 years

Additional details available at www.ncbon.com. Under Quick Links click on the Continuing Competence link.

Something to Think About...

by Thelma Parr, RTM

Increased Numbers of Women Smoking Coincides with Economic Development.



I read an article in RT magazine that said that the more empowered women feel, the more likely they are to light up. This is according to

research published in the World Health Organization Bulletin.

An analysis done in 74 countries found that men are five times more likely to smoke than women in countries with low rates of female empowerment, such as China, Indonesia, Pakistan, Saudi Arabia, and Uganda. In countries with relatively high female empowerment, such as Australia, Canada, Norway, Sweden, and the United States, this gap is small; and women smoke almost as much as men do.

Women's empowerment is measured by the United Nations Development Program using data such as representation in Parliament, voting rights, and comparisons of male and female income, go figure.

"Our study makes a strong case for implementing gender-specific tobacco control activities...such as

much more higher tobacco taxes, more prominent graphic health warnings, smoke-free laws, and prominent graphic health warnings, smoke-free laws and advertising and promotion bans," said Geoffrey Fong from the University of Waterloo in Ontario, Canada, who led the study.

I'm not a smoker, but I have a hard time thinking that this is true. I know a few low income women who are not in power that smoke. Not that it's good for them but they choose to, because they enjoy it. I also know women that are empowered and have high incomes that don't smoke, because they choose not to. People choose to light up every day and people choose to quit every day. **SMOKING IS A CHOICE!!!** In spite of the consequences, people choose to do it.

Just something to think about...

Summer Health Tips continued...

(continued from page 3)

From Store to Home

- Purchase refrigerated or frozen items after you have selected all your non-perishables.
- Put raw meat/poultry in a plastic bag so juices won't cross-contaminate your fruits or vegetables.
- Immediately **refrigerate** all perishable items when you get home.
- **C**ompletely defrost meat/poultry, so that it cooks more evenly and doesn't leave raw or poorly cooked places.

Transporting

When transporting food to another location, whether on a long family

trip or just a short distance to the park, it is important to keep it cold to minimize bacterial growth.

- Keep meats refrigerated until ready to use.
- Pack perishable food from the refrigerator to the cooler just before leaving and keep on ice until ready to use.
- Keep cooler out of direct sunlight and avoid opening it too often.

Hint: Pack beverages in one cooler and foods in another.

Keep it Clean!

Whether preparing food in your kitchen for the backyard grill or putting it all together at the campground, be sure to keep food surfaces clean. And with so many

"cooks in the kitchen", or at the grill, make sure to have plenty of clean utensils and platters on hand. To prevent foodborne illness, don't use the same utensils or platters for raw and cooked meats. If you are headed to the park or campgrounds, find out if there is a source of clean water. If not, bring water for preparing and cleaning. Or pack both dry and wet cloths for cleaning surfaces and hands.





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What is an LTAC?

An LTAC is a Long Term Acute Care Hospital for patients that continue to be acutely ill and require a physician's care each day, just as in a "traditional" hospital. The patients are medically complex and are not going to be ready for discharge in a short period of time.

Carolinah Specialty Hospital has been providing Long Term Acute Care services to the Charlotte region for over six years. Our dedicated team of professional healthcare providers are exceptionally qualified to meet the needs of the LTAC patient.

Each patient at Carolinah Specialty Hospital receives a customized plan of care to meet their specific needs. Each patient's treatment plan is updated weekly by a multidisciplinary team, including the patient and their family. The goal for each of our patients is to return to their highest level of wellness.

Visit us on the web at www.cshnc.com

The Patient I Failed

submitted by Kerrie Burns, DQM

She knew what she wanted. She'd watched her husband of 52 years die on a vent, and followed his wishes to remain a full code. But she knew that was not what she wanted for herself.

So, she wrote a Living Will, had it notarized, gave it to her personal physician, and told all her friends and family what she did not want. She wasn't eligible for a DNR, as she was a healthy 89-year-old, but she knew what she wanted.

"I do not wish my heart to be restarted through usage of any chemical, mechanical or physical intervention..."

Of her 6 children, one fought against her mother's decision, and it was this child, this one desenting voice, who found her mother collapsed on the kitchen floor.

"I do not want any external device to be used to maintain my respiration if my body is incapable of sustaining it on its own."

The daughter told EMS her mother was a full code, and they intubated her on the floor of her kitchen. Once at the ER, her heart stopped, CPR was performed, and her heart was shocked back into a beat. Under the hands of those trying to follow the daughter's wishes, the woman's ribs cracked and broke.

"I wish to die a peaceful, natural death."

She was then sent to ICU, where her heart tried to stop 3 more times. Each time, the broken ribs jabbed and ripped into the fragile muscle and skin as CPR was performed. Electricity coursed across her body and her frail heart was restarted a 4th time. By this time, the other children were there, but the act had been done, over and over. No DNR was written, and the Living Will fluttered impotently at the front of the chart.

"I do not wish artificial means of nutrition to be used, such as nasogastric tubes or a PEG tube."

Her swallowing ability was lost in the storm in her brain that had left her with no voice, no sight, no movement. A scan showed she still had brain activity; she was aware of what was being done to her. Including the PEG tube sank down into her stomach, and the trach in her throat.

"I wish nature to take its course, with only medication to prevent pain and suffering."

The daughter who wanted the mother to remain a full code also refused to allow narcotics to be given, stating she did not want her mother sedated, since she would "wake up" when the correct medical procedures were performed. Her nurses begged the doctor to write a DNR, and he said, "The family can't get it together, and I'm not getting into the middle of it."

"Allow me the dignity we give to beloved pets. Let me die in peace."

I met her one Tuesday night, and spent that night pouring Jevity into her tube, only to suction it back out. Her legs were cool and mottled, her bowel sounds were non-existent, and her blue eyes stared blindly at a ceiling she could no longer see. The MD refused to terminate feedings, but I held them since there was no digestion taking place. The woman was turned and repositioned every 2 hours, and each time, she moaned and gurgled as her lungs slowly filled with fluid. I whispered my apologies as I did the very things to her she tried so hard to prevent.

Suctioning improved her lung function, but would make her body tremble. Over the next 2 nights, she slowly died, all while the daughter demanded more interventions, and maintained that her mother wanted to be a full code. We had read the Living Will. We knew better.

"Thank you in advance for helping me in the last moments of my life to have a gentle, peaceful passing."

She had another stroke, and went back to the ICU, where she was coded until there was not enough surviving heart tissue to maintain a beat. Finally her heart was broken.

And so was mine.

Written by an RN