

Woodlands Limited Pathology Laboratory

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THE BEGINNING

The successful establishment of Woodlands Limited Pathology Laboratory is as a result of a quality driven Managing Director with a vision for this service and an individual with a desire to make quality pathology service in Guyana a reality. A drafted proposal was presented to the Managing Director and team, and the greenlight for this project was signalled on the 29th March 2013.

ESTABLISHMENT

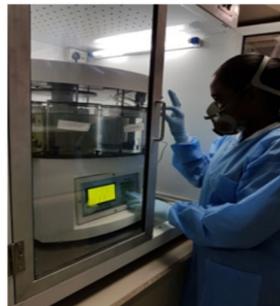
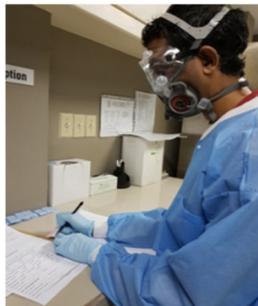
During the years 2013 to 2016, frequent consultation was ongoing to design, develop and eventually establish the pathology laboratory which had proven to provide its own challenges. Nevertheless, state-of-the-art equipment were built, special reagents procured and standardised methodologies were drafted and verification procedures surpassed. However, the test of faith and resilience overcame the many challenges, thanks to the many persons who would have contributed and the continuous support and motivation of loved ones. As a result of an implemented quality management system and safety programme developed according to the Guyana National Bureau of Standards GYS170:2009 and GYS235:2003 respectively, along with all the required technical procedures, the Woodlands Limited Pathology Laboratory officially commenced its operations on the 24th October, 2016.

PRESENTLY

The Pathology Laboratory is manned by a coordinated and dedicated team of Medical Technologists, Laboratory Manager and Pathologist. The services are extended to all medical/healthcare facilities country-wide, with the vision of becoming a national leader in diagnostic pathology services. To date, the Laboratory has efficiently provided quality services to more than 1,170 clients with approximately more than 1500 specimens processed.

The two main areas in which diagnostic services are offered:

Histopathology - the study of changes in tissues caused by disease.



Types of Surgical Procedures for Histopathology Request			Types of Specimen for Cytopathology Request			
Incisional	Excisional	Turnaround Time	Gynaecological	Turnaround Time	Non-Gynaecological	Turnaround Time
Curetting	Cone biopsy	<i>Routine: 7 days</i> <i>Stat: 5 days</i>	Pap smear	<i>5 days</i>	Urine	<i>24 hours</i>
Pipelle biopsy	Open biopsy		Vulval smears		Sputum	
Core Biopsy	Resection		Vaginal smears		Bronchial washings/brushings/BAL	
Endoscopic Biopsy	Amputation		Posterior fornix smears		Bronchial lavage	
Punch Biopsy			Endo pap		Cerebrospinal Fluid	
Shave biopsy					Body Fluids(e.g. pleural, peritoneal, pericardial & synovial fluids)	
				Fine Needle Aspirations (e.g. breast, lung, soft tissue)		
				Scrapings (e.g. nipple, tongue, penis)		

<p>NEWS IN BRIEF</p> <p>SOME STATISTICS FOR AUGUST 2017</p>	<p><u>DOCTORS MEETING:-</u> Was held on , 30th August 2017 at 17:00 hrs.....Chairperson—Dr. N. Gobin Topic: High Risk Surgical Patients by Dr. Navin Rambaran</p>
<p><u>Emergency Room</u> Patients Seen- 2474 Admissions— 79</p> <p><u>Maternity</u> Total Deliveries— 50 Males— 26 Females- 24 Caesarean Sections- 27 Neonatal Death— 0 Twins— 0 Premature— 2 Breech— 0 Still Births— 1</p> <p><u>Male ward</u> Admission— 71 Deaths—0</p> <p><u>Female ward</u> Admission - 143 Deaths—0</p> <p><u>ICU</u> Admissions— 33 Deaths- 3</p> <p><u>Radiology</u> X-ray— 1126 CT— 120 Ultrasound— 2101 ECHO— 62 Holter—0 Stress— 20</p> <p><u>Theatre</u> Surgeries— 154 Ophthalmology — 44</p> <p><u>Pharmacy</u> Prescriptions- 3877</p> <p><u>Laboratory</u> Patients attended-2949</p> <p><u>Pathology</u> Cytopathology- 45 Histopathology- 108</p>	<p><u>NURSES MEETING:-</u> R/N R/M 10th August 2017 N/A 11th August 2017 Topic : Breast Feeding (Baby Friendly) by R/M Althea Bagot</p> <hr/> <p>EMOTIONAL INTELLIGENCE by Customer Service Manager Ms. Carolann Marcus</p> <p><u>Emotional Intelligence</u> and the importance it can play in the hospital. Traditionally, the Intelligence Quotient or IQ, has been the standard for measuring excellence or smarts. The higher a person’s IQ, the smarter they were perceived to be. But are smarts all we need to succeed in life? At our job? In business? How about personal relationships? Some psychologists posit something many laypersons already know. In the early 1990s, psychologists John Mayer and Peter Salovey formulated a concept they called ‘Emotional Intelligence’ (EI). Their theory is that while academics or book smarts are important to landing a good job or running a successful business, it is being emotionally tuned and empathetic that really can make a difference in our professional and personal relationships. But what is this Emotionally Intelligence really? Simply put, it is the capacity to be aware of, control and express one’s emotions and to handle interpersonal relationships judiciously and empathetically. In his book ‘Emotional Intelligence’, (Omnibus, 1995), psychologist Daniel Goleman lists five tenets of EI- Self-awareness, Self-regulation, Self-motivation, Empathy and Social Skills.</p> <ol style="list-style-type: none"> 1) Self-awareness is being aware of our various moods as they are occurring. We ought to be mindful and pause to understand our feelings. Are we angry, sad, indifferent? The first step to any kind of resolution is acknowledging that there is a problem. 2) Self-regulation? Being self-aware is a good first step, but self-control is also critical to emotional growth. Often times we are not able to control what triggers our anger or sadness, but certainly we can control how we respond. We have to take responsibility for our actions and/reactions and ensure that they align with our values. Ultimately, we are accountable for our behavior. 3) Self-motivation is strongly affected by our emotions. When we are distracted by our emotions, we may find it hard to see tasks through. We can boost our motivation levels by developing self-discipline and by looking for and celebrating small wins- simple jobs that when completed give a sense of achievement. 4) Empathy is the ability to put ourselves in another person’s shoes and see their perspective. To help develop this, start by thinking about the other person’s viewpoint. Imagine how they might be feeling and listen actively. Try to listen to understand and not just to respond. This tenet is the fundamental people skill and I’d say the most important of the five. <p>After growing in the previous areas, it would be remiss of us if we were not able to interact with our clients, colleagues, friends or families in a positive manner. We ought to cultivate social skills that help us to interact in any given situation with the same grace and tact we wish to be shown.</p> <p>The art of being emotionally intelligent can help us to be more empathetic, which in turn should translate into better relationships with our colleagues and superior patient care. These augur well as we continue to provide ‘Quality care at affordable prices’.</p>

How and why do we measure Surgical Risk?

Surgical decision-making has evolved over time, and what was once an intuitive matter for surgeons has now become a multi-faceted decision with increased expectations from medical staff and patients, making the decision-making process itself often as challenging as the technical procedure.

When planning the most appropriate treatment for a patient, it is important to distinguish what we aim to achieve with regards to treating the pathology from what can be realistically expected from the patient physiologically. In other words, has the patient the potential to withstand the insult of the treatment itself and what are the risks involved? By quantifying this risk and making it a key part of surgical decision-making, we can arrive at the safest modality of treatment for an individual patient. This allows realistic expectations for the patient, helping them to make an informed decision.

Introduction

Risk has always followed surgery but its prediction has been more recent. Whenever surgery is offered as a potential treatment, it conjures up ideas of risk, particularly when compared with other options. This is reflected in the term 'conservative', used to mean non-surgical management.

Surgical decision-making has evolved over time from what was once little more than personal experience and intuition. However, in some situations this may become so complex that the decision-making process itself can be as challenging as the technical aspects of the surgery. All surgical procedures have complications, which may be considered to be a necessary occupational risk for surgeons. By surgical risk, we mean the risk of major morbidity and mortality to the patient in the perioperative period. Yet risk to both the patient and surgeon is relative. For instance, the risk of 5% mortality may be unacceptably high for a patient undergoing a fundoplication, whereas 50% operative mortality may seem acceptable to a patient with a ruptured aneurysm.

We discuss some of the aspects of surgical risk and its effect on decision-making. The classical view is that this is an issue which is primarily the realm of the surgeon and the anaesthetist. However, we believe that appreciating the complexities of such a process is in the interests of all clinicians.

Popular Patient Assessment and Risk Management

Before addressing the clinical impact and consequences of accurate risk prediction, it is important to appreciate some of the common systems used by clinicians in making these potentially difficult decisions. Although an exhaustive review is beyond the scope of this article, we aim to highlight some of the important points of such tools. Each has its own merits; however, they rely on different information in their estimation of risk, making direct comparisons difficult.

ASA (American Society of Anesthesiologists)

APACHE (Acute Physiology and Chronic Health Evaluation)

POSSUM (Physiological and Severity Score for the Enumeration of Mortality and Morbidity)

At Woodlands we normally use the ASA Classification

ASA 1: No organic pathology or patients in whom the pathological process is localized and does not cause any systemic disturbance or abnormality.

ASA 2: A moderate but definite systemic disturbance. Examples: Mild diabetes. Functional capacity I or IIa. Psychotic patients unable to care for themselves. Mild acidosis. Anemia moderate. Septic or acute pharyngitis. Chronic sinusitis with postnasal discharge. Acute sinusitis.

ASA 3: Severe systemic disturbance from any cause or causes. It is not possible to state an absolute measure of severity, as this is a matter of clinical judgment. Examples: Complicated or severe diabetes. Functional capacity IIb. Combinations of heart disease and respiratory disease or others that impair normal functions severely. Complete intestinal obstruction that has existed long enough to cause serious physiological disturbance. Pulmonary tuberculosis that, because of the extent of the lesion or treatment, has induced vital capacity sufficiently to cause tachycardia or dyspnea. Patients debilitated by prolonged illness with weakness of all or several systems. Severe trauma from accident resulting in shock, which may be improved by treatment. Pulmonary abscess.

ASA 4: Extreme systemic disorders which have already become an eminent threat to life regardless of the type of treatment. Because of their duration or nature there has already been damage to the organism that is irreversible. This class is intended to include only patients that are in an extremely poor physical state. There may not be much occasion to use this classification, but it should serve a purpose in separating the patient in very poor condition from others. Examples: Functional capacity III -(Cardiac Decompensation). Severe trauma with irreparable damage. Complete intestinal obstruction of long duration in a patient who is already debilitated. A combination of cardiovascular-renal disease with marked renal impairment. Patients who must have anesthesia to arrest a secondary hemorrhage where the patient is in poor condition associated with marked loss of blood. Emergency Surgery: An emergency operation is arbitrarily defined as a surgical procedure which, in the surgeon's opinion, should be performed without delay.

ASA 5: Moribund patient with little chance of surviving

ASA 6: Brain-dead organ donor

E Emergency operation Example: An ASA 1 patient having an emergent procedure would be ASA 1E

Further risk-predicting tools

There are now dozens of risk-predicting systems, many including certain facets of the patient's fitness, often focusing on cardiorespiratory function but ignoring other relevant factors (e.g. obesity, which is an independent risk factor for surgery). In fact, a tool encompassing every relevant factor in predicting every risk is difficult to imagine. Where available, a more objective and accurate estimate of the physiological reserve of a patient can be obtained by preoperative cardiopulmonary exercise testing (exercise ECHOs/VO₂ levels). Such tests aim to give a measured idea of risk from co-morbidity but are complex and are not yet widely used. In the future, it is proposed that risk prediction may even include genetic testing, thus predicting patients' response to sepsis, for example.

[Manish Chand](#), [Tom Armstrong](#), [Greg Britton](#), and [Guy F Nash](#) Author information ► (with some modifications)

In the next Volume of the Newsletter we will look at

How risk prediction affects Patient Management, Patient selection, Informed consent, Level of medical care, Surgical outcomes.

Table 2: Special Staining services offered for Histopathology

Special Stain	Turnaround Time
Acid Fast Bacteria	If requested at the time of specimen reception, the turnaround time remains the same for histopathology diagnosis. Or If requested after initial diagnosis, the turnaround time is 3 days after this request.
Amyloid	
Calcium	
Elastic	
Fite's	
Giemsa (May- Grunwald)	
Jones Stain	
Modified Gomori Methenamine-Silver Nitrate (GMS)	
<i>Helicobacter pylori</i>	
Iron	
Mucicarmine (Modified Southgates's)	
Oil Red O	
Periodic Acid Schiff (Modified Lillie's)	
Periodic Acid Schiff for Fungus	
Reticulum	
Trichrome	

Management and Staff wish to congratulate the following persons on their birth anniversary for September 2016



NAME	DATE
Thomasine Aaron	3 rd
Gavin Daziel	5 th
Vanetta James	12 th
Nichola Rodrigues	13 th
Mathew Thomas	13 th
Deonarine Memraj	22 nd
Nalini Bisram	24 th
Anumol Joseph	24 th
Crystal Peniston	24 th
Anthea Thursday	24 th
Seema Lackan	28 th
Marlyn Samaroo	29 th

Vacancies

Security Guard: 1 position
 Attendant: 1 position
 Housekeeper: 3 positions

ALL APPLICANTS WILL BE EXPECTED TO WORK ALL SHIFTS

Welcome to following new employees:

S/N Thomas John, husband of S/N Binsha
 Mr. Brian Marshall – Pharmacy Technician

Congratulations

Mr. Rafman Aneem on his recent marriage, We wish him all the best.

Congratulations

Daughters of Ms. Khemwattie Talmakund, Laboratory Technologist and Theatre Supervisor Ms. Rogers who were successful at their Grade 6 Assessment and CXC Examinations. We wish them the best

TAKING A BREAK FROM WOODLANDS HOSPITAL



Staff	Date
Chitralakha Persaud	3 rd Sept – 23 rd Sept
Natasha Singh	4 th Sept – 7 th Sept
Radha Kalika	11 th Sept -24 th Sept
Rafman Aneem	11 th Sept – 17 th Sept
Shondell Cort	17 th Sept – 7 th Oct
Stacey Hyman	17 th Sept – 14 th Oct
Talfaa Sampson	11 th Sept – 24 th Sept
Tamika Sampson	3 rd Sept – 30 th Sept
Tracey Samaroo	4 th Sept – 17 th Sept

We can now be perused on our Web Site
www.woodlandshospital.com