Nursing Connection!

June 2013
Issue 1

What is *Nursing Connection?*

Nursing Connection is a newsletter developed by members of the St. Luke's University Health Network Nurse Educator group. The purpose is to communicate key pieces of information that are required annually by a variety of accrediting organizations for clinical staff.

This is the first issue…we hope you like it!

Inside This Issue

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Anticoagulation Medications are High Risk!

In 2008, The Joint Commission published the National Patient Safety Goal (NPSG) to address high risk anticoagulation drugs. Implemented January 2009, this goal requires organizations to implement standardized practices in order to reduce harm. Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implants. These medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. Nurses play a key role ensuring that patients receive the full benefit of anticoagulation therapy while acting to minimize potential harm.

Anticoagulant	**Monitor**	**Lab test**	**RN Provides Patient Education** *Use materials approved by Pt. Ed. Advisory Committee and/or Krames On-Demand (KOD)*
(IV) Heparin Prevent/Treat all types of thrombosis and emboli (i.e. DVT, PE, associated with a fib, DIC)	- Requires close monitoring due to narrow therapeutic index, increased risk for bleeding and potential for heparin induced thrombocytopenia (HIT) - Bleeding is the most common side effect (i.e. epistaxis, gum bleeding, hemoptysis, hematuria, melena, or hemorrhage)	aPTT	Increased risk of bleeding, monitor for bleeding, manage bleeding: - report tarry stools - report episodes of bleeding & apply local pressure if indicated - use electric razor - use soft toothbrush
(SQ) Low Molecular Weight Heparin (Lovenox/Arixtra) Treat/Prevent VTE	- Ecchymosis	Platelets	Correct subcutaneous self-administration technique
(PO) Warfarin (Coumadin) Preferred for long term anticoagulation	- Bleeding is the most common side effect most frequently in the GI tract - Drugs that may increase INR-acetaminophen, metronidazole, sulfamethoxalone, omeprazole	INR	- Medication adherence, INR target, laboratory monitoring, diet education. - Foods containing Vit K decrease anticoagulation and INR. Vit K foods should remain consistent to avoid altering anticoagulation effects. - Use KOD: ***Coumadin Teaching***
(IV) Argatroban Treat HIT or history of HIT	- Bleeding is the most common side effect (i.e. epistaxis, gum bleeding, hemoptysis, hematuria, melena, or hemorrhage).	aPTT	Increase risk of bleeding – see heparin.
(PO) Rivaroxaban (Xarelto) Prevent/Treat all types of thrombosis and emboli (i.e. DVT, PE, associated with afib, DIC)	- Unusual bleeding - Avoid invasive procedures - Monitor for neurological compromise - Grapefruit juice may increase levels/effects	Not Required	- Increase risk of bleeding – see heparin - Report neurological compromise (i.e. severe headache, dizziness)

(PO) Dabigatran (Pradaxa) Prevention of stroke in patients with afib	- Unusual bleeding - Avoid invasive procedures - Monitor for neurological compromise - Drugs that may increase serum concentration levels (i.e. verapamil, amiodarone)	Not Required	- Increase risk of bleeding – see heparin - Report neurological compromise (i.e. severe headache, dizziness)
(PO) Prasugrel (Effient) Reduces thrombotic events in patients with acute coronary syndrome	- Suspect bleeding in any patient who is hypotensive and has recently undergone coronary angiography, percutaneous coronary intervention (PCI), CABG, or other surgical procedures - Effient is generally not recommended for use in ≥75 years of age because of the increased risk of fatal and intracranial bleeding and uncertain benefit (except in high-risk situations) - Often given in conjunction with aspirin	Not Required	- Increase risk of bleeding – see heparin - Warn patients not to discontinue the drug without first discussing it with the healthcare provider - Instruct patients to get prompt medical attention if they experience any of the following signs and symptoms that can't otherwise be explained: fever, weakness, extreme skin paleness, purple skin patches, yellowing of the skin or eyes, or neurologic changes.

Ethics Consultation Committee

- The Ethics Consultation Committee is to facilitate communication and shared decision making.
- The Committee is an interdisciplinary team with at least one physician member.
- The team is available to respond within a 24-hour period to hospital staff, patients, families, or other patient advocates.
- The committee serves in an advisory capacity only. Ultimately, the decision-making responsibility lies with the patient/physician.

Ethics Consult Process

RN contacts attending physician

Physician Disagrees

If the attending physician does not agree with the need for an ethics consultation, he/she or the requestor will contact his/her department head and the appropriate medical staff department chair.

Physician Agrees

Order written for consult

Notify Ethics Committee by contacting the Palliative Care Office
484-526-3648
M-F 8:30-4:30
After hours, urgent consults are discussed with the Hospital Supervisor

Committee member will respond within 24 hours

As of June 2013, the Ethics Consultation Committee process is under revision. The information in this newsletter is current at the time of publication.

For further information see:
Ethics Consultation Committee (#26) APPM
Administrative Directive Manual (#AD-PT91/03) - Warren Campus

St. Luke's University Health Network – Domestic Violence, Elder Abuse, Child Abuse

Abuse - Domestic/Family Violence (Administrative Policy #20 Warren Campus AD-PT94/23)

Domestic violence is the physical, psychological, economical and/or sexual abuse of a social partner, usually by a spouse or dating partner. It is characterized by a pattern of coercive control over key aspects of the victim's life including food, sexuality, physical appearance, social life, transportation, work, religion, finances, or access to help and isolation from friends/family.

Risk Factors:

- Adolescent girls
- Women over age 60
- Pregnant women
- Single, separate or divorced women
- Males in homosexual relationships

Indicators of Domestic Violence may include:

- Multiple and/or bilateral injuries particularly involving the head, neck, chest, breasts, back and abdomen, often at different stages of healing.
- Fractures that are a result of significant force or that rarely occur by accident
- Contusions, abrasions, or burns leaving imprint of object used to inflict injury
- Chronic pain
- Repeated visits to doctor's office, clinic, hospital; "accident prone"
- Non-specific pain complaints, persistent gynecological complaints, sleep disorders, anxiety, dysphasia, or hyperventilation in context to normal physical exam.
- Substance abuse, suicidal thoughts, depression.
- Injuries during pregnancy, miscarriage, or premature birth.

Now, What Do You Do…?

- If the patient denies abuse, but there are indicators/risk factors or if the patient acknowledges abuse but refuses additional help the HCW will provide the patient with referral options such as Turning Point of the Lehigh Valley, A Woman's Place, or Schuylkill Women in Crisis.
- Upon identification of domestic violence and the patient is seeking help, the HCW should:
  - Treat the medical problem
  - Document the offer of a referral to the above agencies and whether it was accepted
  - The Case Management Department should be consulted
- In cases of serious bodily injury (self-inflicted or inflicted by another), injuries inflicted by means of a deadly weapon, or death, the hospital **must** report the case to the police.

Abuse – Elder (Administrative Policy #19 Warren Campus AD-PT94/25)

The Older Adults Protective Services Act (Act 79) addresses "older adults" (those 60 and older) who are in need of protective services to detect, prevent, reduce or eliminate abuse, neglect, exploitation or abandonment.

One sign does not necessarily indicate abuse. Some tell-tale signs that there could be a problem are:

- Bruises, pressure marks, broken bones, abrasions, and burns may be an indication of physical abuse, neglect, or mistreatment.
- Unexplained withdrawal from normal activities, a sudden change in alertness, and unusual depression may be indicators of emotional abuse.
- Bruises around the breasts or genital area can occur from sexual abuse. Sudden changes in financial situations may be the result of exploitation. Bedsores, unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect.
- Behavior such as belittling, threats and other uses of power and control by spouses are indicators of verbal or emotional abuse.
- Strained or tense relationships, frequent arguments between the caregiver and elderly person are also signs.

Reporting Elder Abuse

- If Elder Abuse is suspected an immediate referral should be made to the case management department and to the hospital supervisor.
- An initial assessment is completed by Social Work Case Manager/Hospital Supervisor. This assessment will include a determination of the patient's decision making capacity.

Reporting is **voluntary** in Pennsylvania, but acknowledged as necessary in order to provide the patient with the opportunity for Protective Services investigations, and interventions. In cases where competent patients choose to return to at-risk situations, it is important to address patient capacity to understand the implications of their decision, options presented to resolve the problems, and patient's response to options presented.

Abuse – Child (Administrative Policy #18 Warren Campus AD-PT 94/24)

Child abuse encompasses a range of abusive actions or acts of commission, including physical and sexual abuse, and lack of actions or acts of omission including neglect and abandonment, that result in injury or death. Any injury in a child for which there is no logical explanation or injury that is incompatible with the history given or the child's developmental age indicate the potential for child abuse and should be investigated.

Physical Signs of Child Abuse:

- Welts and bruises in various stages of healing
- Fingernail marks
- Human bite marks
- Burns, lacerations, and abrasions in the pattern of an instrument
- Missing, loose, or broken teeth

Did you know…?

- Newborns identified as being affected by illegal substance abuse at their time of birth or who exhibit withdrawal symptoms from prenatal drug exposure are reportable events under recent legislation.
- The Pennsylvania Crimes Code has defined pregnancy as a form of abuse under certain circumstances related to the age of the pregnant child and the age of the father of the baby and as such is reportable to jurisdictional police.

Mandatory Reporting!!!

- It is the responsibility of all hospital personnel and medical staff who in the course of their employment, occupation or practice have contact with children to report suspected child abuse as per the Child Protective Services Law (Childline 1-800-932-0313).
- The Case Management Department must be informed of all suspected child abuse or neglect cases being reported to Childline or local Children and Youth agencies in order to ensure appropriate follow-up with the Child Protective Services Agency.

Preventing MDROs

What is MDRO?
Multi-drug resistant organisms.

What does it mean?
Organisms have become resistant to the drugs normally used to treat them (antibiotics).

Preventing MDROs can be achieved by using a variety of interventions including:

- diligent hand hygiene
- use of Contact Precautions for all MDRO patients
- environmental cleaning

Handwashing is the single most effective way to prevent the spread of germs. Healthcare workers should wash their hands before and after treating a patient and/or after touching any environmental surface in patients' rooms.

Personal protective equipment, like gowns and gloves, also helps to reduce the risk of spreading MDROs from the patients and the surfaces they may have touched in the room.

Cleaning and disinfecting both patient care items and room surfaces also help to prevent the spread of MDROs.

Patient and family education specific to MDRO's should be addressed and documented to help reduce the risk of transmission.

Print it out!
Go to: Krames > Browse > National Patient Safety Goals > Healthcare Associated Infections > Multi-drug resistant organisms.

HCAHPS and VBP: What does it all mean?

(John Marcantonio, Network Director Patient Experience)

HCAHPS is an acronym for **H**ospital **C**onsumer **A**ssessment for **H**ealthcare **P**roviders and **S**ystems. The assessment represents the first national, standardized, publicly reported survey of patients' perspectives of hospital care. It was developed in 2006 by CMS (Centers for Medicare and Medicaid Services) to compare hospitals to each other for a public website (www.hospitalcompare.hhs.gov).

With fiscal year 2013, the scores of these surveys now partially determine its reimbursement rate to hospitals. Value-based-purchasing designates the pay-for-performance method by which the CMS retains 1% (increasing gradually to 3%) of its payments for hospitals to either earn back or lose to better performing hospital. In its first year, reimbursements were determined through a formula that weighted patient experience 30% and clinical measures 70%. The patient experience contains eight (8) "domains" (Nurse Communication, Doctor Communication, Hospital Staff Responsiveness, Pain Management, Medicine Communication, Environment- Cleanliness & Quietness, Discharge Information and Overall Rating).

HCAHPS uses "top box" rather than an average score of rating numbers; this means that the score is the percentage of the best possible answers. For most of the survey items, HCAHPS uses a frequency scale; participants' choice of responses is: never, sometimes, usually, and always. Only the "always" responses are counted for the score. Three questions are asked for nurse communication (identical questions are asked of doctors): *During your stay, did the nurses (1) treat you with courtesy and respect, (2) listen carefully to you, and (3) explain things in a way that you can understand?* If 90% of the responses were "usually" to any of these questions, and 10% were "always," the score would be 10%.

Cultural Competency

Cultural competency refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Understanding Cultural Differences

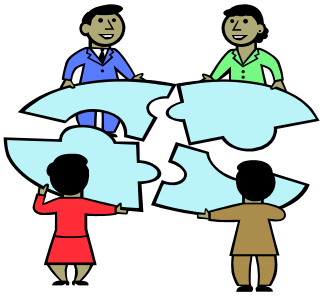
- As cultures and societies move geographically, they bring with them the aspects of their lives with which they identify themselves and find comfort
- Culture is linked to the way emotions, mental distress, social problems, and physical illness are perceived, experienced, and expressed
- The patient must be allowed to rely on his or her own source of support, and health care providers must be mindful of verbal expressions and body language that convey personal bias and disagreement
- Professionals do not have to accept patients beliefs, however professionals must treat each individual as a unique being who is worthy of medical care
- Professionals must be conscious of their own perceptions and potential differences

Example of Cultural Differences

A Vietnamese woman, after giving birth to a son, refuses to cuddle him but she willingly provided minimal care such as feeding and changing his diaper. The nurse feeling sorry for the baby, picked him up, cuddled him and stroked the top of his head. Both the mother and the husband became visibly upset.

This apparent neglectful behavior does not reflect poor bonding, but instead indicates a cultural belief and tradition. Many people in rural areas of Vietnam believe in spirits. They believe these spirits are attracted to infants and are likely to steal them (by inducing death). The parents do everything possible not to attract attention to their new born, for this reasons infants are not cuddled or fussed over.

This apparent lack of interest reflects an intense love and concern for the child, not neglect.



Communication and Cultural Competence

- Through cultural conversations and understanding, professionals can implement culturally sensitive medical care
- Recognize your own behavior and communication styles and be willing to adjust
- Be aware of body language, gestures and nonverbal cues
- Speak clearly, be supportive and respectful

Conclusion

Rather than attempt to learn an encyclopedia of culture-specific issues, a more practical approach is to recognize a set of common problems that occur in cross-cultural medical encounters.

Five core cross-cultural issues that should be taken into account are:

- styles of communication
- mistrust and prejudice
- decision-making and family dynamics
- traditions, customs, and spirituality
- sexual and gender issues

Once a potential core issue is recognized, it can be explored further by inquiring about the patient's own belief or preference, which may be quite different than the "cultural norm."

For additional information:

Robert, D., Moussa, M., & Sherrod, D. (2011). Foster cultural responsiveness on your unit. *Nursing Management*, 52-54. Retrieved from www.nursingmanagement.com.

NASW (2001). NASW standards for cultural competence in social work practice. *National Association of Social Workers*. Retrieved from http://www.socialworkers.org

Brach, C. and Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57,* 181-217.

Spencer, C. & Burke, P. (2011). The impact of culture on pain management. *Academy of Medical Surgical Nurses, 20 (4),* 1, 13-15.

Betancourt, J., Green, A. and Carrillo, J. E. (2012). Cross-Cultural Care and Communication. Retrieved from http://www.uptodate.com

Pain Management

(K. Cunningham, P. Trapani, M. Kipila)

No one could ever begin to know or judge the pain experience of another individual… The overall goal of pain management is to keep the patient's pain score low enough to enhance the quality of life, allow for recovery, and reduce complications.

Practice Reminders

Assessment:

- Assess personal, cultural, spiritual, and/or ethnic beliefs that may impact a patient's perception of pain.
- SLUHN uses a numeric pain rating scale of 0 -10. An assessment tool, appropriate to the patient's age and ability to communicate, is used to characterize pain location, intensity, and effectiveness of interventions.
- Assess the patient's response to pain intervention(s) within an appropriate timeframe. *If sleeping, the patient will be assessed for comfort, e.g. normal respirations, relaxed positioning, lack of restlessness, no grimacing. If the patient meets these criteria which indicate that the patient is comfortable, it is appropriate to document "sleeping" as a post medication pain assessment. If the patient does not meet these criteria, the nurse should awaken the patient to assess the need for additional pain relief interventions.*

Interventions:

- Pharmacologic
- Complimentary – repositioning, distraction, massage, imagery, music, play, etc.

Documentation:

- Presence/absence of pain on admission, patient's past experience with pain, reassessments, interventions, effectiveness of interventions, patient/family education, discharge planning
- Pre and post intervention pain rating using the appropriate pain scale/assessment tool
- Pain Care Plan to ensure pain goals are being met

Keep in mind… It is important to communicate to the patient that it may not be possible to completely relieve his/her pain. Changing the patient's perception of having pain "under control" and clearly defining what that means to him/her is vital. Therefore, the pattern of pain relief, not the pain severity, may be the critical determinant of satisfaction.

SLUHN Resources:

Pain Management Policy (D-23)
- Nursing Policy & Procedure Manual

Programs on MyNet (Learning Page)

- Pain Management PowerPoint (0.5 CE)
- Pain Management Video (1.25 CE)

Organ and Tissue Donation

Did you know the nursing staff and all members of the team work together to support the family through this process?

- Remember the donation process is a *family driven* process. Every effort is made to ensure they are supported and their unique needs are met.
- Ensure that families are receiving constant and simple updates regarding the gravity of their loved one's condition.
- Allow time for bedside prayers, body cleansing, and support for large groups.
- Coordination of diagnostic studies, etc. should be planned by the health care team to limit the time the family is kept from the bedside.
- Remember to consider any particular belief system a family maintains. If the family requires special prayers, or practice, support that being carried out.
- Hospital chaplains often work in partnership with the families own clergy. Sometimes, the chaplain is the only source of spiritual support. Connections to community leaders of particular faiths are sometimes sought if the donor/donor family is not from the area.
- For those experiencing loss, case managers often partner with the organ and tissue team in a variety of tasks, including locating next of kin, finding resources for funeral homes, and support for families who may be far from home.
- Communication and collaboration are extremely important during these cases. The organ and tissue team depends on the nursing staff to keep them updated on the patient as well as the family.

Consult the Appropriate Organ & Tissue Group (Gift of Life, Sharing Network, Lions Eye Bank) for more information

To preserve the organ donation option for patients/families, follow the following criteria: ***(regardless of age, medical history, current hospital course, hemodynamic status)***

1. At the first indication the patient has suffered a non-recoverable neuro injury/illness (patient begins to lose some neuro reflexes)
2. Prior to the first formal brain death examination
3. Prior to family discussion of DNR or withdrawal of support
4. Patient has suffered: Head Trauma, Anoxia, CVA

In collaboration with the care team, the appropriate organ and tissue group will initiate the first mention of organ donation (after it has been determined that the patient is a medically suitable candidate for donation)

For more information:
Donation of Organs/Tissue/Eyes – APPM #11
Warren Campus AD-PT 91/07

Patient Safety and Quality

Performance Improvement and Quality:

- Our *goal* is to achieve optimal outcomes with continuous, incremental improvements which consistently represent best practice standards, minimize risks to the patient and organization, improve customer satisfaction, and are cost-effective.
- St Luke's monitors performance through data collection and analysis. Relevant information is then integrated into Performance Improvement initiatives.
- An important aspect of improving Network performance is effectively reducing factors that contribute to unanticipated adverse events and/or outcomes.

Patient Safety and Event Reporting:

- Any healthcare worker or physician who suspects, discovers, witnesses or to whom any type of patient related event is reported is responsible for completing an Event Report.
- **Event reports are submitted on-line via the Patient Safety Event Reporting System located on MyNet.**
- This process is intended to document and report unusual occurrences, including but not limited to, Adverse Outcomes, Errors, Near Misses, Medication Errors and Adverse Drug Reactions.
    - Click here for specific event types

Efficient reporting serves to facilitate the timely identification, analysis, resolution, and documentation of actual and potential risks. Event Reporting directly enhances the quality and safety of patient care throughout our organization.

- In order to facilitate prompt reporting, our staff is expected to report events involving actual or suspected patient harm via the Patient Safety Hotline. This hotline is a 24/7 voice mailbox, messages are retrieved during normal business hours (Monday-Friday) and a completed Event Report is still required.
- It is important that the report provides a complete description of the facts and circumstances as they occurred; avoid opinion, admission of fault or assignment of blame.
- In addition to the event report, all patient safety events should be documented in the medical record. The medical record should include the following:
    - A brief factual description of the event
    - Immediate effect on the patient, if known
    - Name of the physician, or designee, notified and time
    - Any immediate physician orders, if applicable
    - The medical record should **not** include documentation that an Event Report was completed or submitted.
- Upon submission, the Event Report should be reviewed by the manager, or their designee, of the departments involved and Clinical Risk Management.

Creating a Culture of Safety instead of a culture of blame is the *key* to our success with event reporting.

"To Err is Human" established and written in 1999 determined that as many as 98,000 people die every year in hospitals as the result of medical errors that could have been prevented. These errors lead to loss of trust in the healthcare system, decreased satisfaction by patients and health care professionals as well as loss of morale and frustration. We are getting closer to a culture of "why" errors occur and not "who" made the error when reviewing these event reports and providing feedback and strategies to prevent them from reoccurring.

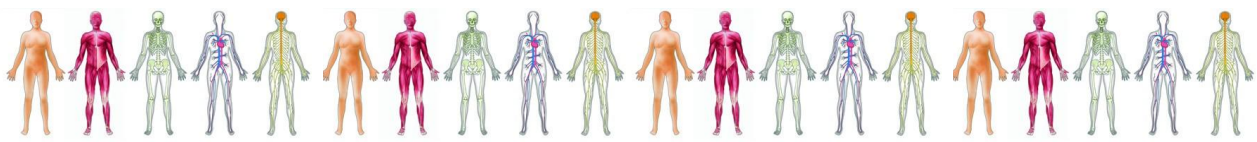
Reminder:
Insulin *Pens*

- ✓ Improper use of insulin pens can place individuals at risk for infection with pathogens including hepatitis viruses and human immunodeficiency virus (HIV).
- ✓ Insulin Pens should **never** be used for more than one person, even if the needle is changed
- ✓ Ensure that the insulin pens are **labeled** with the patient's name on the barrel not the cap.
- ✓ Ensure that all insulin pens are removed from medication boxes after the patient is discharged.
- ✓ If reuse is identified, call the Safety hotline, complete an event report and notify your manager/supervisor.

The *High Risk Medication Staff Committee* recently recommended that the network move away from using shared patient medication boxes/cabinets to decrease the chance on inadvertent medication mix – ups. This recommendation was approved and shared medication boxes will soon be eliminated.

UNIVERSAL SKIN CARE/PRESSURE ULCER PREVENTION

UNIVERSAL PRACTICES	Positioning Guidelines	Interventions for Incontinent Patients
Inspect the skin, paying particular attention to the bony prominences	Use pillows and proper positioning of patients to provide support, separate skin surfaces, and prevent skin breakdown	Ordinarily adult incontinence garments are used when incontinent patients are out of bed or are transported off the unit
Check skin folds of patients, especially obese patients where skin touches skin	Relieve pressure under heels by using pillows or heel suspension devices	For incontinent pads normally use 1 at a time
Use moisturizing products on dry skin & feet but not in between toes	Turn and/or reposition the patient at least every 2 hours, as patient condition permits	Clean the patient's skin with mild soap or incontinent cleaners to remove urine or feces and dry after each incontinent episode
Use powder sparingly especially in skin folds or creases	Do not place the patient directly on the trochanter when side-lying	Use moisture barriers to prevent irritation caused by drainage and/or incontinence
Avoid massage over reddened areas or bony prominences; consider the use of protective ointment over bony prominences to reduce friction injury	Do not position patient head of bed >30° in side-lying position	Consider a noninvasive pouching system or collection device to contain urine or stool to protect the skin
Powder the rim of the bedpan to minimize friction	Do not slide the patient across the bed surface to avoid pulling or dragging, which can cause friction injuries	All invasive collection devices require a physician's order
Encourage activity and mobility as patient condition permits	Consider a trapeze if the patient has upper body strength to help with movement	
Remove antiembolism stockings daily to provide skin care	Do not allow patient to remain in high fowler's position for extended period of time unless medically necessary	
Report presence of any red or broken skin areas	When seated, position chair-bound patients with attention to anatomy, postural alignment, distribution of weight, and support of feet. Chair bound patients should be repositioned to shift points that are under pressure at least every 2 hours. Consider using pressure reducing (devices) for chairs.	
Offer ordered nutritional supplements		



RAPID RESPONSE TEAM

To Activate RRT: (Adult, Pediatric, obstetric) Dial "5555" state your campus, type of RRT, location and room number

Neonatal Response Team (Allentown/Bethlehem only)
Pediatric Response Team (Bethlehem campus) for patients 17 yrs. or less.
Perinatal/Antenatal Response Team (Allentown/Bethlehem-OB depts.)

To Activate CAT (Warren campus) Dial "0"

Criteria for RRT Call *(All teams)*

Are you worried about your patient? Are you seeing signs that your patient's condition may be deteriorating?

- Acute change in heart rate
- Acute change in blood pressure
- Cool, clammy skin with poor pulses
- Acute change in respiratory rate, respiratory distress, changes in oxygenation despite supplemental oxygen?
- Acute mental status change and or displaying acute stroke symptoms, seizures
- Urinary output less than 50 ml in 4 hours
- Uncontrolled bleeding, cardiac chest pain

70% of patients show evidence of respiratory deterioration within 8 hours of cardiopulmonary arrest. 66% show abnormal signs and symptoms within 6 hours of arrest.

Early identification, assessment and stabilization before condition deteriorates will reduce morbidity and mortality.

You CARE so you CALL

C: You are concerned
A: Anxious
R: Resources are needed
E: Empowering teamwork

Goals of the Rapid Response Team

Rapid response teams were designed to assist acute care staff and patients in need before the situation leads to arrest.

The RRT team:

- **Will provide assistance with patient assessment**
- **Implement necessary interventions based on developed protocols**
- **Provide support and just in time education as needed for staff**
- **Improved collegiality between departments and areas**
- **Reduce Code Blue calls by early intervention**
- **Help Save Lives**

What are staff responsibilities when the RRT team comes to your unit??

- Utilize SBAR format to communicate with team
- Have available the following:
  - Patient's medical record
  - Current medications, allergies
  - Recent vital signs
  - Reported lab /diagnostic results
  - Code status
- Initiate and complete the RRT record-make sure it is signed by the RRT physician/advanced practitioner
- Keep white copy and place in patient's medical record
- Yellow copy goes to Unit Manager

Surgical Care Improvement Project

Specifications Manual for National Hospital Inpatient Quality Measures (applicable 1/1/2013 through 12/31/2013). The SCIP (Surgical Care Improvement Project) focuses on reducing surgical complications through performance measurement and quality improvement efforts. These efforts are based on evidence and research. SCIP measures with rationale include:

MEASURE	RATIONALE
Antibiotic received within 1 hour prior to surgical incision (2 hours for vancomycin and flouroquinolones)	The lowest incidence of post-operative infection is associated with antibiotic administration during the one hour prior to surgery. The risk of infection increases progressively with greater time intervals between administration and skin incision.
Prophylactic antibiotic selection for surgical patients	A goal of prophylaxis with antibiotics is to use an agent that is safe, cost-effective, and has a spectrum of action that covers most of the probable intraoperative contaminants for the operation.
Prophylactic antibiotic discontinued within 24 hours after surgery end time	Administration of antibiotics for more than a few hours after the incision is closed offers no additional benefit to the surgical patient. Prolonged administration does increase the risk of Clostridium difficile infection and the development of antimicrobial resistant pathogens.
Cardiac surgery patients with controlled 6am postoperative blood glucose	A study conducted in Leuven, Belgium (Van den Berghe, 2001), demonstrated that intensive insulin therapy not only reduced overall in-hospital mortality but also decreased blood stream infections, acute renal failure, red cell transfusions, ventilator support, and intensive care.
Appropriate hair removal - clippers, not razors	In a randomized study of 1,980 adult patients undergoing cardiopulmonary bypass surgeries, Ko, et al (1992), reported a significantly higher rate of infection among patients who were shaved with a razor than those who had hair removal by electric clippers before skin incision.
Foley removed on post-op day 1 or post-op day 2.	The risk of catheter-associated urinary tract infection (UTI) increases with increasing duration of indwelling urinary catheterization.
Patients with a temperature of 96.8°F or 36°C within 30 minutes prior to end of anesthesia or 15 minutes immediately after anesthesia end time.	A study by Kurtz, et al (1996), found that incidence of culture-positive surgical site infections among those with mild perioperative hypothermia was three times higher than the normothermic perioperative patients. In this study, mild perioperative hypothermia was associated with delayed wound closure and prolonged hospitalization.
Patients on Beta Blockers prior to arrival received BB during perioperative period – day prior, through post-op day 2.	Current studies suggest that appropriately administered beta-blockers reduce perioperative ischemia, especially in patients considered to be at risk (Eagle 1997). It has been found that nearly half of the fatal cardiac events could be preventable with beta-blocker therapy (Lindenauer 2004).
Surgery patients with venous thromboembolism (VTE) prophylaxis ordered. (Athrombic Pumps)	According to Heit, et al, 2000, surgery was associated with over a twenty-fold increase in the odds of being diagnosed with VTE. Studies have shown that appropriately used thrombo-prophylaxis has a positive risk/benefit ratio and is cost effective. Prophylaxis recommendations for this measure are based on selected surgical procedures from the 2004 American College of Chest Physicians guidelines.
Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	Timing of prophylaxis is based on the type of procedure, prophylaxis selection, and clinical judgment regarding the impact of patient risk factors. The optimal start of pharmacologic prophylaxis in surgical patients varies and must be balanced with the efficacy-versus-bleeding potential. Prophylaxis recommendations for this measure are based on selected surgical procedures from the 2008 American College of Chest Physicians guidelines.

Phlebotomy Key Points

Identify patient---ask the patient: "What is your name and DOB?"

- **Always label all tubes in the presence of the patient**! Compare ALL lab labels for the intended draw against the patients ID band
- Apply label **vertically** on tube from the stopper down—leave a "window" available so as to see the blood in the tubes—**date /time and initial all tubes**
  *Indicate **SITE** of draw on blood culture bottles*

Keep things clean:

- Wash your hands **first** before starting procedure
- Wipe off table surface before placing items needed for blood collection onto table top
  - Maintain sterility of venipuncture needle/butterfly

When looking for site:

- **Tourniquet should not be on for more than 1 minute.**
  - Remove if it took you long to find a vein and re-apply once you are ready to perform your draw
  - Remove tourniquet once blood begins to flow into tubes—this helps to prevent hemolysis.
    - Avoid use of tourniquet with lactate draws.

- **Allow alcohol to AIR DRY BEFORE you stick the patient**
  - Alcohol lyses cells causing a hemolyzed specimen and can cause hemodilution of specimen—plus it is painful to the patient during venipuncture

- ***For Adults*: Use Chlorhexadine prep to cleanse the skin when drawing blood cultures**
  For Infants <28 weeks gestation AND < 1 week old: Betadine is used to cleanse the skin
  - You must allow it to air dry for best antimicrobial effect
    - (takes about 15-30 seconds—do not blow on or fan the site)
    - Aerobic bottle is drawn first (for pediatric patients: use PINK bottle)

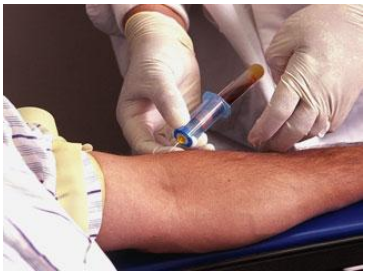
- **Follow correct order of draw every time** to ensure accuracy of lab value results (Lab Manual)

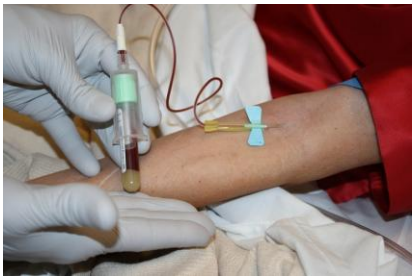
- Gently mix tubes by inverting them—never shake the tubes

- **Best way to obtain blood is via direct venipuncture---antecubital region**
  - Butterfly draws should only be used for very small fragile veins, pediatric patients and when drawing blood cultures. **Butterfly sets can cause hemolysis of specimen**
  - If a butterfly is used—draw a discard tube when collecting **BLUE** tubes to ensure blue tube is full

- **Avoid drawing blood from an arm with an IV running**. If you must, draw below the IV site and turn off the IV for a 1-2 minutes prior to collection

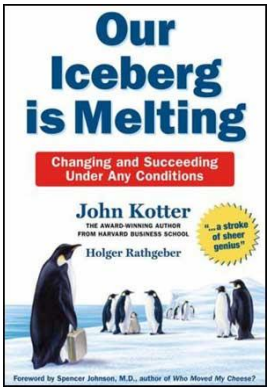
- **Consolidate lab draws**:
  - If a test is ordered late, see if it can be added to prior blood work or if it can wait until the next lab draw time.





Strategies and **T**ools to **E**nhance **P**erformance and **P**atient **S**afety

Team STEPPS™ is an evidenced-based framework to optimize team performance across the health care delivery system.



Team STEPPS™ is composed of four teachable-learnable skills:

- Leadership
- Mutual Support
- Situation Monitoring
- Communication

Communication is the core of the team STEPPS™ framework!

Team STEPPS™ focuses on specific skills supporting team performance principles. This system is unique in that it includes training requirements, behavioral methods, human factors, cultural change – all designed to improve quality and patient safety.

Key communication strategies used in various departments across SLUHN include:

Ticket – to – Ride

This paper form is completed by the nurse and placed on the patient's chart before transport. It is used to convey key information between the nursing unit and testing departments about the patient.

SBAR

Format for report giving at time of patient hand off between caregivers (oral or written); S = Situation; B= Background; A = Assessment; R = Recommendations

Procedure Time Out

Prior to any invasive procedure, entire team stops to ensure patient identity, procedure, site, etc. before starting anything invasive

Questions about how TeamSTEPPS™ can benefit your unit or department?
Discuss with your manager or supervisor.