"Risky Business", Staff -Patient Safety Newsletter
St. Joseph Medical Center

Program/Project Description.
When reviewing medication incident report data, we observed that similar errors were occurring in different areas of the hospital. We were not learning from our mistakes, because we had no way of communicating to nurses on all units about these errors. The newsletter started as an initiative from the Medication Safety Committee as a means to communicate about medication errors and lessons learned. We did not want each nurse or each unit to repeat a particular error before we learned from it as a group. Members of the committee felt that competencies were not the best method for ongoing communication. Monthly competencies would not be reasonable and once nurses completed the online competency test, the material was no longer available as a resource.

Process.
The idea for a newsletter evolved from monthly discussions within the Medication Safety Committee as we searched for an effective way to communicate with nurses throughout the institution. We had a name for the newsletter six months before the newsletter actually started. Each month the committee encountered situations that were ideal for communication in a newsletter format. After similar incidents related to high alert meds and the doublecheck process occurred in different units of the hospital, we were on the verge of adding another nursing competency when we decided the time was right to move forward with the newsletter.

Solution.
The newsletter started as a completely volunteer, unpaid, staff driven effort. There was no budget and no committee or meetings involved in creating the newsletter. All communication was done by email or phone conversation between two people working totally different shifts. The very first newsletter was written over a weekend and forwarded to the Director of Clinical Practice for input and approval. We presented that first "issue" to the Medication Safety Committee for approval, and distributed at Nurse Practice Council (NPC) that month. The newsletter has always been an internally produced document printed in the hospital printshop each month.

Measurable Outcomes.
1. Newsletter provided means to communicate with nursing staff about errors and to communicate information from vital SJMC committees including: Environment of Care, Patient Safety, Medication Safety, and NPC.
2. The volume of distribution has steadily increased. Newsletter is now distributed monthly to NPC, Patient Safety Committee, PI Council, and Nursing PI. It is posted on the nursing units and on the intranet Department of Nursing site. It is also posted in the physician lounge and distributed via email to all physicians since Sept 2010.
3. A vast array of educational topics have been addressed including: high alert meds, rapid response teams, staff injuries, nursing scorecard, handoffs, influenza/ vaccines, computerized incident reporting, anticoagulants, OB emergency response team, improving allergy and home med documentation, patient falls, root cause analysis, central line bundle, vascular access pointers, pressure ulcer prevention, communication, Smart Pump technology, hyperglycemia treatment, James Reason's Swiss cheese theory of errors, and prevention of central line associated blood stream infections (CLABSI).
4. Multiple departments have been highlighted in past issues: Employee Health, Dietary, Risk Management, Maternal Child Health, Infection Control and Prevention, Vascular Access, Wound Ostomy Care, Diabetes Education, Pharmacy, Blood Bank/Lab, and IT/computer documentation.
5. The scope of the newsletter has changed over time. The newsletter started with nursing and the original focus was communication of medication safety issues. It has evolved into a multidisciplinary newsletter with a focus on increasing overall Culture of Safety awareness.
6. Led to organizational recognition of need/value of patient safety communication exhibited by creation of a 20hr/week Patient Safety Liaison Position to work with the Director of Quality Management/ Patient Safety Officer and to continue the newsletter on a monthly basis.
7. Culture of Safety Survey results from October 11- October 29, 2010. Eighty percent of respondents agreed we are actively doing things to improve patient safety and seventy four percent of staff agreed they will freely speak up if they see something that may negatively impact patient care.
8. Use of technology to expand newsletter. Posted on the hospital intranet nursing website. All back issues are easily accessible and the ongoing number of hits can be seen.

9. “Risky Business” as part of a comprehensive educational program has led to a twenty percent increase in online incident reporting since 2008 based on 2010 annualized data.

10. Led to development of a Patient Safety logo which will be instrumental in branding of our patient safety awareness campaign.

**Sustainability.**

1. “Risky Business” newsletter will celebrate its 3 year anniversary in February 2011.

2. Creation of a 20hr/week Patient Safety Liaison position to work with the Director of Quality Management/Patient Safety Officer. Responsibilities include continuation of the newsletter and active participation on Patient Safety and Medication Management Committees and Nurse Practice Council.

3. Conscious decision to maintain the newsletter as 1 page front and back, with multiple graphic additions to maintain staff interest and increase staff willingness to read.

4. Special features in each issue include: Case Scenario, “Name that Safety Device”, ISMP Corner, and Quickie Reminders.

5. Volume of distribution has steadily increased. “Risky Business” newsletter is distributed monthly to members of: Nurse Practice Council, Patient Safety Committee, PI Council, and Nursing PI. It is posted on the nursing units and on the intranet Department of Nursing website. It is also posted in the physician lounge and is distributed via email to all physicians since September 2010.

**Role of Collaboration and Leadership.**

The newsletter initially started as a volunteer, staff driven effort and ultimately led to creation of a 20 hr/week Patient Safety Liaison Position. Although the newsletter originated in the Medication Safety Committee, it was shared with members of the Patient Safety Committee within the first few months. The “Risky Business” newsletter is now on every Patient Safety Committee, PI Council, and Nurse Practice Council agenda to discuss the current issue and seek ideas for future issues. The Director of Clinical Practice serves as cowriter, editor, and technology expert. We utilize clinical experts as appropriate when drafting monthly topics. Our Risk Manager collaborates on the final draft as we balance transparency with discoverability.

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PREVENTING CLABSI

SJMC is proud to announce that we have reduced Central Line Associated Blood Stream Infections (CLABSI) by 62% this calendar year. This is fantastic testament to infection prevention and patient safety. We have had great success and continue to strive for zero CLABSiS. Together, we can do it!

A central venous catheter, or central line, is an intravascular catheter that terminates at, or close to, the heart or in one of the great vessels and is used for infusions, blood withdrawal or hemodynamic monitoring. ** Remember: Peripherally Inserted Central Catheters (PICCs) are considered central lines.

FAST FACTS:
- Estimated 250,000 central line associated bloodstream infections occur annually in the US, and 14,000-28,000 deaths occur annually due to central line infections in the US
- $25,000 cost per episode; up to $56,000 per episode in ICU
- 48% of ICU patients have central lines
- Annual cost of CLABSI in the US is estimated to be as high as $2 Billion.

The Center for Disease Control (CDC) has 2 strict definitions for CLABSi. Essentially the patient must have a central line and a positive blood culture. When the blood culture result is a common skin contaminant, the definition is more involved.

CASE SCENARIO: CENTRAL LINE INSERTION

Scenario 1: It is 2am and Dr. X asks you to assist him with insertion of a triple lumen catheter. You’ve never met this physician. How can you verify he is credentialed to insert central lines?

- Go to Status Board in Meditech, click Print Report, Select Patient Care Menus, Physician Credentialing
- You can search by physician or privilege.
- Providers must be credentialed to insert central lines.

Scenario 2: You confirm Dr. X is credentialed to insert central lines. As you complete the central line checklist, you watch Dr. X don his sterile PPE, but did not witness him perform hand hygiene.

- Speak up!
- Inform Dr. X you did not see him perform hand hygiene and it’s a required element of the bundle.
- He states he already washed his hands. Kindly ask him to wash again since you didn’t witness the original hand hygiene.

Scenario 3: While cleansing the skin with choraprep, Dr. X performs two quick strokes instead of using back and forth motions for 30 seconds. What should you do?

- Speak up!
- Kindly remind the physician on the proper prepping instructions, back and forth strokes for 30 seconds and allow to air dry for 30 seconds.

Scenario 4: Patient has an order to dc the central line but the patient has a peripheral IV that is 4 days old and poor peripheral access. The patient also has significant edema of the upper extremities.

- Consult with vascular access nurses before discontinuing.
- Do not discontinue a central line unless the patient has patent, asymptomatic peripheral access.

The Nursing Staff at SJMC are empowered to supervise the preparations using the central line checklist prior to line insertion and to STOP the procedure if any step is performed incorrectly! You will be supported in your actions.
PREVENTING CLABSI (continued)

Prevention of CLABSI requires consistent use of the central line checklist with diligent attention to each detailed step in the checklist by every practitioner. Education on the prevention of CLABSI is located inside the Central Line Bundle Bag or within KRAMES and must be provided to the patient and/or family as able.

Completing a central line checklist at the time of insertion will help to ensure that all steps are executed for each and every line placement. This has been proven to reduce infections! If you witness a breach in infection prevention procedure during a central line insertion, please call Infection Prevention (x1396) immediately!

Beginning December 1, 2010 an electronic central line checklist will be going LIVE in Meditech. To reach the Electronic Central Line Checklist order Intervention, “Central line insertion”. The Universal Protocol is included within this Electronic Central Line Checklist. Stringent preparation, ongoing assessment, and aseptic handling of the line once it’s inserted all contribute to reducing central line infections.

CLABSI Quick Prevention Tips:

1. Hand hygiene is the single most important way to prevent the spread of infection. Please be sure to perform hand hygiene prior to accessing a peripheral or central line.

2. Scrub the hub with alcohol prep for 15 seconds:
   a. Scrub the “end cap” or “hub” of the peripheral or central line
   b. Scrub the Y-connection site on IV tubing
   c. Only use the “sterile blue syringe tip cap” for all IV tubing not in use.

3. Appropriate assessment
   a. Daily, assess the continued need for central line
   b. Assess the insertion site for signs/symptoms of infection every 8 hours
   c. Assess the dressing every 8 hrs (does the dressing need to be changed)
   d. Date, time, and initial IV tubing and IV fluid bags

4. Flush central lines per protocol ensuring there is no visible blood residual left in the tubing
   a. When a line becomes occluded it greatly increases the risk of BSI.
   b. Please contact Vascular Access when a line is occluded or flushing becomes sluggish.
   c. Utilize Vascular Access Department (IV therapy) for assistance. Remember to use comment section when placing your request.

QUICKIE REMINDERS

BLOOD CULTURES

1. Every effort must be made to draw the first blood cultures before the initiation of antimicrobial therapy.

2. Paired blood cultures (2 sets equals 4 bottles) provide more useful information than single blood culture (1 set equals 2 bottles)

3. Blood cultures should not be routinely drawn from intravascular devices unless strongly suspecting device associated bacteremia.

4. If blood cultures are ordered through the central line, peripheral blood cultures must also be ordered.

5. Do not routinely culture the tip of a discontinued central line.

To further decrease CLABSI, SJMC uses the BIOPATCH during central line insertions and dressing changes. Prepping the skin during insertion of a central line is not enough, as 60% of CLABSIs originate from the patient’s own skin. BIOPATCH is a chlorhexidine gluconate (CHG) impregnated sponge dressing. CHG is a potent antibacterial and antifungal agent that is recommended for ongoing skin antisepsis. It is uniquely designed to continually release CHG over 7 days, providing 360 degrees of protection. BIOPATCH is the ONLY product of its kind PROVEN to reduce bloodstream infections in patients with central venous and arterial catheters and can be found bundled with our central lines or in your Pyxis supply machines.

Hint: To work most effectively the Biopatch must: completely encircle the catheter with the radial slit aligned with the catheter, and the blue/arrow facing side upward.

ANSWER: “NAME THAT SAFETY DEVICE”? BIOPATCH
High Alert Medications

WHY HIGH ALERT?
Diligence is taken when we give all medications but due to the nature of the medications and documented errors certain medications are deemed high risk. These high risk medications need additional steps to ensure patient safety. One of the most important steps is a Double check prior to administration.

HIGH ALERT MEDS:
- Insulin
- PCA/PCEA
- Injectable potassium (>10meq /100ml)
- IV heparin
- Hypertonic sodium chloride (3%)
- Magnesium sulfate IV and oxytocin (MCH only)
- Chemotherapeutic agents (cytotoxics, antineoplastics)
- NICU/ Pediatric medications

WHAT ARE THE DOUBLE-CHECK STEPS?
- the order
- patient ID (name, DOB, wristband)
- the label on the bag for med name and dose
- expiration date
- pump settings
- medication tubing is plugged in to the mainline IV
- document

Safety Quotes:

Errors hurt, safety doesn’t

For safety is not a gadget but a state of mind. ~Eleanor Everet

What is your safety quote? If you have a tidbit to inspire others in safety, let the Medication Safety Committee know.

FUTURE TOPICS:
- FALLS
- RESTRAINTS
- PRESSURE ULCERS

The Medication Safety Committee (MSC) is a subcommittee of the Pharmacy & Therapeutics Committee. The committee is comprised of direct care nurses, pharmacists, physicians and administrators. The overall goal of the MSC is to assess the med safety needs of SJMC and implement safe medication practices. The committee reviews:
- medication incident reports,
- adverse drug events,
- policies & procedures,
- reports from ISMP (Institute for Safe Medication Practice) &
- reports from TJC (the Joint Commission).

Medication errors are defined as any actual or potential errors within the medication administration process. Reporting a "near miss" is an opportunity to prevent future errors.

Email the group "MedSafety" for more information or ideas. Your Manager or Unit Based Pharmacist are valuable for more information.