Organization: Mercy Medical Center  
Solution Title: Weekly Safety Rounds: A Collaborative Approach to Patient Safety

Program/Project Description: What was the problem to be solved? How was it identified? What baseline data existed? What were the goals—how would you know if you were successful?

Patient safety is a priority across all healthcare settings, but is especially important in the critical care arena. Given the myriad of patient safety initiatives that must be addressed, nursing was challenged to develop a strategy to not only maintain focus on each initiative for each patient but also, to effectively monitor progress and outcomes. Our ongoing goal is to provide safe patient care as evidence by excellent patient outcomes.

Process: What methodology or process was used to develop the Solution?

The methodology used to maximize focus and compliance with all safety initiatives in the Critical Care Unit was the implementation of weekly safety rounds completed by a nurse designated as the "Patient Safety Lead (PSL)."

Solution: What Solution was developed? How was it implemented?

In 2005, Mercy Medical Center joined forces with the Institute of Healthcare Improvement and many other hospitals to prevent unnecessary illness and death of patients. At that time, Mercy Medical Center created a part-time position in the Critical Care Unit for a Patient Safety Lead who implemented many evidence-based interventions. Over time, it became increasingly more difficult to track and manage the compliance with safety interventions. In 2008, in response to a Ventilator Associated Pneumonia (VAP) root cause analysis, weekly rounds were initiated to assess compliance with the VAP Bundle. The rounds were successful by providing a forum for real time education/correction, as well as, to increase the focus on the VAP Bundle and VAP Prevention. Over time, additional items were added to the weekly rounds. Initially, Deep Vein Thrombosis (DVT) prevention, alarm appropriateness, and medication safety were added. Because of the success of the rounds, Catheter Associated Urinary Tract Infection (CAUTI), Central Line Associated Blood Stream Infection (CLABSI), Weights, Falls, and Hospital Acquired Pressure Ulcer (HAPU) prevention were also added. These rounds include collaborating with the nurse at the bedside and evaluating and discussing each safety issue pertinent to the patient. For example, if the patient is a high fall risk, evidence-based interventions are reviewed at the bedside to insure full implementation of fall prevention strategies. In addition, nursing and physician documentation is reviewed and discussed.

Measurable Outcomes: What are the results of implementing the Solution? Provide qualitative and/or quantitative results to data. (Please include graphs, charts, or tools as attachments.)

The biggest success can be seen in our VAP rate. The Critical Care Unit has not had a VAP in over 2 years. In addition, since this is a well established program, it is an excellent forum for rapid cycle improvement. As issues arise in the ICU, they can be evaluated during safety rounds and discussed with the bedside nurse. An example is our compliance with daily weight documentation. Following implementation of weekly rounding, the compliance rate improved from 60% to 90%. Another example is our CLABSI prevention. Central Line Rounds recently revealed only a 78% compliance rate with correct placement of the chlorhexadine disc. Following 6 weeks of focus, 96% compliance was achieved and maintained. This intense focus also led to the identification of barriers to compliance, which were resolved.
Sustainability: What measures are being taken to ensure that results can be sustained and spread?
As with any program, sustainability is the biggest challenge. It is important that the safety rounds are consistently implemented. In times of increased workload and competing priorities, it is important not to omit the rounds or decrease the importance of completing them thoroughly - persistence and diligence are key. In addition, rounds must be completed for both day and night shift in order to ensure patient safety 24/7.

Role of Collaboration and Leadership: What role did teamwork and collaboration play in the Solution? What partners and participants were involved? Was the organization’s leadership engaged and did they share the vision for success? How was leadership support demonstrated?
Collaboration between the PSL and the bedside nurse has evolved and improved over time. Initially, the PSL completed rounds independent of the bedside nurse and then communicated findings. Currently, the PSL performs bedside rounds with the each patient's nurse. The collaborative approach has provided a more meaningful experience for the nurse and supported comprehensive incorporation of patient safety into daily nursing care.

Nursing leadership has been engaged and supportive of the safety initiatives in the Critical Care Unit. This is evidenced by providing 12-24 hours per week devoted to the PSL position. Additionally, patient safety is included in our nursing shared governance structure and all staff meetings.

Innovation: What makes this Solution innovative? What are its unique attributes?
This patient safety solution is innovative, relatively easy to implement and highly effective. It allows for a conscious review of many important patient safety initiatives. It adds another level to safety that is not routinely seen in other institutions. I am not aware of any other organization that has incorporated weekly safety rounds, performed by a critical care nurse, dedicated as Patient Safety Lead in collaboration with other critical care nurses. This is a novel and effective approach and can be used as an exemplar for advancing patient safety at all levels.

Contact Person: Christine Brown
Title: Critical Care Patient Safety Lead/Education
Email: crbrown@mdmercy.com
Phone: 410-659-1512