Newsletter

Special Edition

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This ***Special Edition*** of the Deans' Roundtable Faculty Initiative Newsletter is dedicated to a discussion of The Joint Commission's National Patient Safety Goals and the pivotal role of the registered nurse in the safe care of our patients and the Clinical Faculty role in student nurse education.

National Patient Safety Goals: The Role of the Registered Nurse

In 2002, The Joint Commission convened a panel of physicians, nurses, pharmacists, and other patient safety experts to advise the group on the development of its first set of national patient safety goals. The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems that have been identified in the delivery of health care and on how to solve them based upon the evidence and exemplars of patient-safety strategies.

Beginning January 1, 2003 more than 17,000 Joint Commission-accredited health care organizations that provide care relevant to these goals were required to provide evidence of compliance with this first set of six goals: 1.) improve accuracy of patient identification, 2.) improve effectiveness of communication between providers, 3.) improve safety of high-alert medications, 4.) eliminate wrong-site, wrong-patient and wrong-procedure surgery, 5.) improve safety of using infusion pumps, and 6.) improve the effectiveness of clinical alarm systems. In 2009 there are now sixteen identified patient safety goals (Website reference: http://www.jointcommission.org).

Nurses are critical in the promotion and assurance of patient safety. Our 24-hour surveillance and care of the patient affords nurses the opportunity to serve as the critical constituent in this promise of safe care. Many of the safety goals are foundational to our nursing practice: patient identification, correct medications and dosages, communication to other providers, reducing risks that could result in falls or infections, and rapid identification of changes in the patient's condition. We are pivotal providers in the safe care of patients and rigorous adherence to these foundational nursing practices is a must and should be a standard in the practice of expert nurses.

The Clinical Faculty role is essential in the education of nursing students regarding these safety goals and the accountability of nurses in assuring safe care. With this in mind, it is essential for you to be current in your knowledge of the National Patient Safety Goals and familiar with the exemplars of nursing practice that assure safe patient care and minimize risks to our patients. Clinical Faculty must guide students toward incorporating these nursing interventions into the patient's plan of care and encourage them to monitor patient outcomes and assess ongoing risks for all patients. You are on the units with the students, providing patient care, so it is important for you to serve as the role model and expert in safe patient care.

We should be proud of our part in creating a safe environment and providing safe care for our patients. Be vigilant in the assessment of risks that could impact safe care. Do not be hesitant to model and to remind other providers of appropriate safe patient care. For many years the public has identified nursing as the most trusted profession (Gallup Organization); what an honor!

Inside this issue:

Participating Organizations:

- Bryant & Stratton College
- Frances Payne Bolton School of Nursing at Case
- Center for Health Affairs
- Cleveland State University
- Cuyahoga Community College
- Hiram College
- Huron School of Nursing
- Lakeland Community College
- Lorain County Community College
- Kent State University
- Marymount School of Nursing
- Notre Dame College
- Ohio League for Nursing
- University of Akron
- Ursuline College

Patient Safety: Hand-off Communications

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In the healthcare setting, hand-off communication is the avenue for the sharing of information between caregivers about a patient. This vital communication effort should happen face to face and include critical patient information to assure safe patient care and improve patient outcomes. The Joint Commission reported that poor communication between caregivers accounts for 60% of the failures analyzed after a critical patient event. Improving communication between caregivers is essential in the hospital's strategic plan in order to reduce and eliminate medical errors. The Joint Commission recommends a standardized approach to hand-off communication at all healthcare organizations for the improvement of patient safety.

All of us, at one point, have experienced frustration while talking to a physician or other healthcare provider about a patient care issue. Have you ever felt the person receiving the message was not really listening to what you had to say or that they already had their own idea of what they really wanted, regardless of your input? This is not an uncommon occurrence. One methodology for hand-off communications that is utilized in many healthcare settings is the SBAR communication technique. SBAR was originally developed by the U.S. Navy to improve communication during submarine launches and other critical incidents and then was adapted by Kaiser Permanente of Colorado in the obstetrical services. SBAR stands for situation, background, assessment and recommendation, which allows patient care givers to provide objective and subjective data, opinions, and request an intervention. It is a change in practice that requires an expected communication pattern in which the steps are easily recognized.

Definition of SBAR:

S= Situation: What is going on with the patient? A concise statement of the problem including the patient's name and location.

B=Background: Give the admission diagnosis and the date of admission, provide pertinent medical history and a brief synopsis of the treatment to date.

A= Assessment: Provide a summary of your assessment, including any signs and symptoms, describe the problem.

R=Recommendation: What action / recommendation is needed to correct the problem? What do you want to see done for the patient?

Nurses should utilize hand-off communication as they begin their care of each patient. Example: **S- Situation** – Mr. Smith is in room 214, he is a 32-year old male who has just returned from radiology following a KUB. **B-Background** – He was admitted for a kidney stone and has not yet passed it according to the KUB. **A-Assessment –** He received some additional morphine IV push about 10 minutes ago and is resting more comfortably with a pain score of 3/10. **R-Recommendation –** He will need his vital signs rechecked in 15 minutes and a reassessment of his pain status in 2 hours. He needs to continue to drink fluids and to strain his urine.

Using the SBAR communication technique streamlines communication and captures the crucial information. The critical pieces of information shared between caregivers can be custom designed to meet the needs of differing caregivers such as occupational therapists and physical therapists or differing treatment areas such as Radiology.

As clinical faculty you should role model this form of communication, helping to improve the hand-off communication between nurses and nursing students, thereby establishing the practice of using this as the standard form of communication between caregivers early on for our students. Pre and post conference discussions could incorporate the use of SBAR communication when discussing patient care situations. SBAR could also be utilized in simulation labs to discuss and practice hand-off communication.

Nurses are the leaders in the integration of patient care. Our skills in communication are critical pieces in assuring safe patient care and good patient outcomes. We can be the providers who establish the standards and then encourage all others by our expectations of communication content and format.

Reference:

Institute for Healthcare Improvement, SBAR Technique for Communication: A Situational Briefing Model

http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

Improving the Safety of Medication Administration

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Medication errors can happen at anytime during the medication process, from the writing of the order, to the obtaining of the medication from the pharmacy, to the administration of the medication, to the monitoring of the effects/side effects of the medication. Many drugs sound and look alike, orders may be unclear, and illegible handwriting may make it difficult to determine drug name, route, and dosages. According to a study by the Institute of Medicine "a hospital patient can expect to be subjected to more than one medication error each day." This translates into increased patient length of stay, not to mention an increased cost to the hospital. For this reason The Joint Commission identified "Improve the Safety of Using Medications" as one of the 2009 National Patient Safety Goals. The purpose of this goal is to establish standard safety measures within the hospital to decrease the incidence of medication errors.

The three main requirements of this goal are:

1. Prevent errors involving medications that sound or look alike. (S.A.L.A.D.).
2. Label all medications, medication containers, and solutions.
3. Reduce the likelihood of patient harm associated with anticoagulation therapy.

Let's look at some of the safety measures that have been put into place to help reduce medications errors related to these three areas.

SOUND ALIKE LOOK ALIKE DRUGS

Hospitals are required to identify, review, and update these medications annually. You should be able to locate this list in the Hospital/ Pharmacy Policy. Usually, there will be a list of these medications in the medication room.

Medications with similar names should be kept separate from each other or the bins should be flagged with a bright color to catch your attention. This will remind you to double check the medication you are removing for the patient.

The use of **Tall Man** lettering to high-light the differences in spelling is another technique used to draw your attention to these **S.A.L.A.D** medications. This emphasizes the subtle differences in the spelling of the medication.

- Glipi**ZIDE** & glyburide
- predni**SONE** & prednisolone

By listing both the generic and the brand name of the medication on the MAR or EMAR it is easier to identify a mistake. Also, the order should include the intended use of the medication. When the doctor writes the reason for the medication it acts as another trigger to double check the medication you are going to administer. By knowing the purpose of the medication before administering it to the patient, you may prevent a potential error.

LABEL ALL MEDICATIONS, MEDICATION CONTAINERS OR OTHER SOLUTIONS

Basically this refers to any medications that are drawn up into a syringe to be used at a later time. The safest thing you can do is to immediately label the syringe noting the name and strength of the medication. While this will most likely happen in the perioperative area where anesthesia draws up medications, or in a procedural area like Endoscopy, it can also occur on a nursing unit.

The label should include the name of the medication, the strength, the amount, and the time the medication was drawn up. Some medications are stable for a short period of time and might expire before it is used. You should always keep the original box available for reference until the procedure is completed.

REDUCE THE LIKELIHOOD OF PATIENT HARM ASSOCIATED WITH THE USE OF ANTICOAGUALTION THERAPY

The use of anticoagulant therapy is a high risk treatment that can result in patient harm. For this reason hospitals are required to have a standard concentration of all forms of anticoagulants, oral unit dose products, pre-filled syringes, and pre-mixed infusion bags.
Patients are closely monitored and therapy should be initiated and maintained according to approved hospital protocols.

For patients starting on warfarin for long term anticoagulation therapy or prophylaxis, (DVT or atrial fibrillation) a baseline INR (International Normalized Ratio) is required prior to receiving the first dose. Subsequent doses are then based on current INRs and the dose is adjusted to maintain a therapeutic range.

Observing the 5 Rs of medication administration is essential in assuring safe medication administration. Clinical Faculty must role model and hold students accountable for this process of safety. Asking these questions prior to each medication administration is critical:

- Is this the right drug?
- Is this the right dosage?
- Is this the right time?
- Is this the right route of administration?
- Is this the right patient?

Use of two patient identifiers is required to assure you are giving the medication to the right patient. Common identifiers are patient name, birth date, and hospital ID number. The nurse should minimize all distractions while he/she is preparing and administering medications. Interruptions are a common theme in medication errors.

Reducing preventable medication errors demands the attention and involvement of everyone and it is everyone's professional responsibility to maintain and work within that culture of safety.

Infection Control: Hand Hygiene and Cough Etiquette

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As part of the healthcare team, all clinical instructors and nursing students have a responsibility for infection prevention and control. There are effective methods for reducing the potential for transmission of infections from healthcare workers to patients and from patients to healthcare workers. Two of the most effective and simplest methods for prevention of disease transmission are through proper ***cough etiquette*** and ***hand hygiene***. All patients admitted to any Cleveland Clinic facility are asked to watch a Patient Safety Video. This video encourages them to remind the health care team to wash their hands.

While using an alcohol-based hand rub is appropriate for many situations, the use of soap and water may sometimes be required.

All healthcare workers ***MUST*** wash hands with soap and water:

- When hands are dirty or visibly soiled with blood or body fluids
- After using the restroom
- Before eating
- When caring for patients with *Clostridium difficile* or *Bacillus anthracis*

What is the proper hand washing technique using soap and water?

1. Wet hands with warm water Avoid using hot water as repeated exposure to hot water may increase the risk of dermatitis.
2. Apply 3-5 ml (about a teaspoon) of soap to hands.
3. Rub together vigorously for at least **15 seconds**. Cover all surfaces of the hands, fingers, and wrists paying careful attention to the areas between fingers and around nail beds.
4. Rinse hands completely with warm water.
5. Dry thoroughly with a paper towel using disposable towels.
6. Use a dry paper towel to turn off the faucet to avoid recontamination of hands.

If hands are not visibly soiled an alcohol-based hand rub may be used for routinely decontaminating hands in all other clinical situations. Alcohol-based hand sanitizers have been installed throughout our facilities to promote hand washing. Together we can work to prevent the spread of infection to our patients and one another.

Hand Hygiene Technique using an alcohol-based hand rub is:

1. Apply product to palm of one hand following the manufacturer's recommendations (golf ball-sized, if using foam) regarding the amount of product to use.
2. Rub hands together until dry, making sure to cover all surfaces of the hands. Pay careful attention to the areas between fingers and around nail beds.

Keep the following tips in mind when using gloves for hand hygiene:

- Wear gloves when contact with the following: blood, excretions, secretions (except sweat), mucous membranes, and non-intact skin could occur.
- Remove gloves after care and prior to next contact.
- Change gloves after contact with contaminated body site before moving to clean site.
- Use hand hygiene immediately after removing gloves

Nail Care

- Instructors, students, and employees with direct patient care or food handling responsibilities ***MAY NOT*** wear artificial nails (e.g., acrylic or nail wraps).
- Natural nails are to be kept short and polish, if worn, may not be chipped.

All healthcare workers have the potential for exposure to infectious materials including body substances, contaminated medical supplies, equipment, environmental surfaces, and air. Personnel who have contact with patients, body fluids, and specimens have a higher risk of transmitting or acquiring infections.

To prevent the spread of respiratory infections, you need to contain respiratory secretions by following cough etiquette:

- Use tissues to cover your nose and mouth when you cough, sneeze, or blow your nose.
- Clean your hands after you cough, sneeze, or blow your nose.

If you are ill with a respiratory or other condition that might be contagious, please stay home and follow your procedure for calling in. Remember the patients you are caring for may have compromised health conditions and you cannot subject them to flu, pneumonia, or any respiratory conditions that would further harm them.

Remember to get the flu, pneumonia (if you qualify), and the N1H1 vaccines as soon as they are available. We need to protect our patients and each other!