SCRMC CULTURE
OF SAFETY MODULE
Purpose:
Introduce SCRMC’s Culture of Safety to new nursing employees

Process:
Non-licensed - read slides 1-28; licensed staff completes entire course; both must complete quiz with 80% score or greater

Questions:
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Ext. 4929
Safety threats exist in healthcare!

Our Culture of Safety depends upon:
- Good communication
- Reliable documentation to identify what the risks are and what preventive measures need to be taken.
CHAIN OF COMMAND

- Unit staff>
- Charge Nurse>
- Unit Director>
- Clinical Coordinator>
- VP of Nursing Administration, Chief Nursing Officer>
- Chief Executive Officer>
- Board of Trustees

Report your concerns or suggestions for improved patient, guest, and staff safety!
Errors in communication have been identified as the number one cause of medical errors that harm patients!

S – B – A – R communication between team members when necessary improves patient safety.
S – Situation or Subject- What is the purpose for the exchange of information?

B – Background- What information in the patient’s history is relevant to this communication?

A – Assessment – What pertinent, current findings need to be exchanged – lab, VS, complaints, signs and symptoms?

R – Orders, Results, Requests- Were relevant results reported? Were orders received?

AND, don’t forget to

E – Evaluate- Has the situation changed? Do other resources need to be informed?

D – Document- Record care provider notified, the specifics of information exchanged and the outcome of that communication.
<table>
<thead>
<tr>
<th>Do Not Use Abbreviations</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U or u (unit)</td>
<td>Enter “unit”</td>
</tr>
<tr>
<td>IU (International unit)</td>
<td>Enter “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Enter “daily” or “q day”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Enter “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)</td>
<td>Enter “X mg”</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td>Enter “0.X mg”</td>
</tr>
<tr>
<td>MS, MSO4</td>
<td>Enter “morphine” or “morphine sulfate”</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Enter “magnesium” or “magnesium sulfate”</td>
</tr>
<tr>
<td>&gt; (greater than); &lt; (less than)</td>
<td>Enter “greater than” or “less than”</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td>Enter full drug name</td>
</tr>
<tr>
<td>@ (at)</td>
<td>Enter “at”</td>
</tr>
<tr>
<td>CC (cubic centimeter)</td>
<td>Enter “ml” or “milliliter”</td>
</tr>
<tr>
<td>µg (microgram)</td>
<td>Enter “mcg” or “microgram”</td>
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</tbody>
</table>
Not a HIPAA violation

Team member communication regarding specific patient needs:
- NPO
- Specific type of transmission precautions
- Fall risk
PATIENT IDENTIFIERS

- Name and date of birth

- *Check patient identification band;* don’t just ask the name.

- *Check ID band information, especially the FIN, to be certain it’s for THIS admission!*

- DON’T OVERLOOK OR BYPASS THIS BASIC STEP IN PATIENT IDENTIFICATION AND ERROR PREVENTION!
HEALTHCARE ASSOCIATED INFECTIONS - HAIS

- Not only harmful to our patients, but lengthens patient stay, costs more for their care, and negatively effects our reimbursement!

- Frequently occurs because of a “staff” infection – germs passed from patient to patient by staff members' hands!

- “Have you seen Hannah?” is a phrase that can remind fellow staff members to perform good hand hygiene.
HAND HYGIENE

- **Soap and water**
  - When hands visibly soiled
  - Before eating
  - After using the restroom
  - When patient has “C. Diff” infection

- **Alcohol hand sanitizer**
  - Before and after gloving
  - Before and after patient contact
  - Between patients
  - After touching contaminated objects – overbed table, side rail, remote control, dressings, IV tubing, Foleys, etc.
CAUTIs – Catheter associated urinary tract infection

- Nursing driven removal of Foleys
- Be sure there is an approved reason for the Foley using the acronym C – H – O – R – U – S:
  - **Comfort**—measures for the terminally ill or incontinent patient with open sacral or perineal wounds
  - **Hemodynamic monitoring**—close, accurate monitoring of urinary output for aggressive treatment of diuretics, fluids, pressors, etc.
  - **Obstruction**—anatomic or physiologic outlet obstruction (enlarged prostate, blood clots, etc.)
  - **Retention**—urinary retention not being managed by other means; immobilization
  - **Urologic**—urologist or other physician placed urinary catheter, urologic studies, neurogenic bladder, chronically indwelling catheter present on admission
  - **Surgery**—urologic, gynecological or perineal surgeries, pre and post op orthopedic fracture

MOST COMMON HAIS
Keep Foley tubing coiled on the bed; avoid dependent loops in tubing.

Keep Foley bag below the level of the bladder.

Perform Foley care with soap and water at least daily and when soiled.

Each shift, nurses on the inpatient units document in Cerner the indication for the Foley or pursue orders for discontinuing the catheter.

Remember to ex-FOLEY-ate ASAP!
Always use aseptic technique with dressing and tubing changes.

CHANGE dressing if not occlusive

NEVER loop distal end of tubing and attach to lowest injection port to “store” tubing disconnected from site. Use red cap or end of saline flush syringe to cap tubing to keep sterile.
HEALTHCARE ACQUIRED PNEUMONIA

- Elderly, immobile patients at greatest risk!
- Keep head of bed elevated 30° if not contraindicated.
- Frequent oral care.
- Turn, cough, and deep breathe! Keep patients moving!
- Increase mobility – get patients out of bed!
- Use good hand hygiene.
SSIS - SURGICAL SITE INFECTIONS

- Practice good hand hygiene before and after surgical site care!

- Use aseptic technique with dressing changes, staple/suture removal.

- Teach patient/family about incisional care at home. (If an infection occurs within 30 days of surgery, it is considered an SSI an adversely affects our reimbursement plus negatively impacts the patient.)
FALLS lead the list of healthcare associated conditions for patients, guests, and staff!

SCRMC uses a “Falling Leaves” sign, a yellow arm band, a yellow door magnet, and yellow non-skid socks to indicate a patient at risk for falls.

Clean up spills, trash, etc. when found or notify Environmental Services if involved area too big for simple paper towel cleanup.

EVERYONE is responsible for fall prevention!
#1 priority after a fall is to assess the patient and attend to their immediate needs! Notify the physician and the family.

Document the “Post Fall Assessment” found in the Ad Hoc section of Cerner.

Conduct a “Fall Team Huddle” as soon as possible with all team members involved in the patient’s care to discuss the possible causes for this fall and preventive measures to avoid future falls.

Complete the “Inpatient Post-Fall Team Huddle” form found in InfoRouter and give to the unit director.
Assess the patient’s skin on admission and every shift for skin impairments using the Braden Scale. The lower the number, the greater the risk for skin breakdown!

Keep patients clean, dry, and repositioned in the “30-30 club” – head of bed elevated no more than 30° and turned 30° on their side to the “fat pad” of the buttocks instead of the coccyx (tail bone) or trochanter (hip bone).

Braden score of 15 or less automatically generates a WOCN consult.
The MOST PREVENTABLE cause of hospital deaths!!!

Know the patients at risk – immobile, venous stasis, and/or clotting disorder.

Stress to patients to keep SCDs on all the time in the bed or sitting in the chair.

Make certain TED hose are the correct size, fit properly, are free of wrinkles or bunching up, and are removed at least daily for skin inspection, ADL’s, etc.

Give anticoagulants appropriately and timely.

Get patients out of bed and moving ASAP!
Restraints are the last resort for medical-surgical healing or behavior control.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Non-violent</th>
<th>Violent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr. order</strong></td>
<td>Obtained within 1 hour of application</td>
<td>Obtained within 1 hour</td>
</tr>
<tr>
<td><strong>Order includes</strong></td>
<td>Purpose, time limit, type, &amp; indication</td>
<td>Same</td>
</tr>
<tr>
<td><strong>Time limit</strong></td>
<td>72 hrs without reordering</td>
<td>4 hrs without reordering</td>
</tr>
<tr>
<td><strong>Initiation</strong></td>
<td>By an RN based on pt assessment</td>
<td>By trained clinical staff</td>
</tr>
<tr>
<td><strong>Dr. notification</strong></td>
<td>Within 1 hour of initiation</td>
<td>Within 1 hr of initiation</td>
</tr>
<tr>
<td><strong>Dr. assessment</strong></td>
<td>Within 24 hours</td>
<td>Within 1 hour</td>
</tr>
<tr>
<td><strong>Pt monitoring</strong></td>
<td>Nurse observations Q 2 hours</td>
<td>Continuous observation</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td>Monitoring documented Q 2 hrs</td>
<td>Monitoring documented Q 15 minutes</td>
</tr>
</tbody>
</table>
Patients seen for suicide attempt, suicidal thoughts, or suspected psychiatric diagnosis are screened for suicide risk factors using the *SAD PERSONS* scale.

Total number from the scale is reviewed by the physician to assist in determining the course of treatment.
# SAD PERSONS SCALE

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Low Risk</th>
<th>0</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (gender)</td>
<td>Female</td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Age</td>
<td>20 – 45 years</td>
<td></td>
<td>Less than 19 or older than 45 years</td>
</tr>
<tr>
<td>Depression</td>
<td>Mood is NOT significantly depressed</td>
<td></td>
<td>Mood IS significantly depressed</td>
</tr>
<tr>
<td>Prior attempts</td>
<td>No prior attempts</td>
<td></td>
<td>1 or more prior attempts</td>
</tr>
<tr>
<td>ETOH</td>
<td>Not ETOH or drug dependent</td>
<td></td>
<td>Is ETOH or drug dependent</td>
</tr>
<tr>
<td>Rational thought (loss of) or psychosis</td>
<td>No psychotic symptoms</td>
<td></td>
<td>Psychotic symptoms</td>
</tr>
<tr>
<td>Support/lack of</td>
<td>Has emotional &amp;/or social support</td>
<td></td>
<td>No significant emotional or social support</td>
</tr>
<tr>
<td>Organized plan</td>
<td>Simple ideation or impulses</td>
<td></td>
<td>Articulates an organized plan</td>
</tr>
<tr>
<td>No spouse</td>
<td>Family support or significant other is available</td>
<td></td>
<td>No spouse or significant other</td>
</tr>
<tr>
<td>Sickness</td>
<td>No medical problems causing stress</td>
<td></td>
<td>Medical problems not well controlled &amp; causing stress</td>
</tr>
</tbody>
</table>

Recommended guidelines for interventions based on points given:
- **0 – 2**: Outpatient follow up; assist with appointment
- **3 – 4**: Supervised, supported outpatient follow up; hospitalization for some patients
- **5 – 6**: Hospitalization unless safe alternative arranged and verified; psychiatric consult
- **7 – 10**: Hospitalization; may need involuntary confinement; psychiatrist consult
Clinical alarms – nearly all hospital equipment has built-in alarms to alert users about malfunctions, misconnections, patient status and more.

Alarm settings may be adjusted on some equipment by the user; some are preset by the manufacturer or our BioMed department.

ALARMS ARE NEVER TO BE TURNED OFF; they may be silenced for a brief period while the issue is addressed.
ALARM FATIGUE

- Ever left work and arrived at home to realize you don’t remember passing a particular place like a store, a stop sign, etc.? Similar things happen at work too…..

- Staff hears multiple “sounds” or alarms daily – call lights, bathroom pull cords, IV pumps, and more; sometimes “without hearing.”

- ALWAYS be alert to every alarm – check the patient first, then the cause for the alarm. The alarms are there to help you keep our patients safe while items are in use.
Any piece of equipment that continues to alarm, is not working properly, or not working at all is to be replaced with another like piece of equipment immediately.

Place red-orange “Defective” label on equipment and return to BioMed for evaluation.
Rapid Response Call is intended as a method for any nurse to be able to obtain additional assistance/assessment with a patient that may have a deteriorating condition but has not “coded” yet. This process and response is under review and revision at present.

Additional information will be forthcoming to all staff when available.
Did you know that the patient’s perception of the care we give them effects our “grade”? 

CMS (Center for Medicare/Medicaid Services) makes available to the public hospital ranking in comparison to national, state, or local scores through medicare.gov under “Hospital Compare”. 

Hospitals are ranked based on many factors, such as patient satisfaction scores, 30 day readmission rates, patient outcomes compared by diagnosis and length of stay, care processes, and efficiency or cost of care.
NURSE SPECIFIC INFORMATION

Critical Lab Values

- Nursing will be notified by lab personnel by phone of a patient’s critical lab value.

- That nurse has one (1) hour to notify a provider involved in that patient’s care of the critical value.

- That notification is documented in Cerner IView/I&O under “provider notification.”
MEDICATION ADMINISTRATION
SAFETY

- Scanning the patient’s armband & the medicines AT THE POINT OF CARE (POC) is the expected standard for all areas using the hand-held scanners.

- Patient ID by checking armband for name & date of birth is to be used by ALL areas.

- Scanning performs drug-drug interactions, drug-allergy interactions, and the “rights” of medication administration at the time given.

- DO NOT rely on asking the patient his/her name only!!
Informed consent is given by the physician; nursing witnesses the patient signature!

BE CERTAIN the consent is completely filled out BEFORE signed by patient/patient’s representative!

Licensed professional must witness.

Patient should sign for himself/herself if at all possible.

Place any signed document in the patient’s paper chart record.