Vanderbilt University Medical Center

VUAH Quality Guidelines

Nursing Education & Professional Development

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Preventing Central Line-Associated Bloodstream Infections (CLABSI)

- Help to prevent CLABSIs by following these guidelines:
    - Place a **swab cap** on all accessible ports, including IV tubing, on patients with a central venous catheter (CVC)
    - **Scrub the hub** with an alcohol swab 5 times around the hub and 5 times over the hub (5x5) and ensure it is dry before accessing the line, every time
    - The frequency for dressing changes is dependent upon the type of dressing being utilized on the CVC:
        - CHG dressings are changed every 7 days and PRN using sterile technique
        - Gauze dressings are changed every 2 days and PRN using sterile technique
    - Ensure the central line is secured appropriately with sutures or stat lock, as appropriate
        - There is not a securement device available for all types of lines, i.e. ports or needles
    - Ensure dressings are **clean, dry, intact** and **labeled** with date and initials
    - Evaluate the continued need for the CVC each shift and advocate for the line removal as soon as it is determined it is no longer needed
    - When a new central line is placed, use all new tubing and IV bag before connecting to new IV site
    - Use colored labels to indicate date to change tubing

Every 96 hours	• IV solution and medication tubing • Transducers and pressure tubing • TPN infusion tubing for pediatrics
Every 72 hours	TPN infusion tubing for adults
Every 24 hours	Tubing containing intralipids Note: Propofol tubing is changed every 12 hours
Every 4 hours	Blood product administration tubing

- Refer to the following policy and recommendations:
    - Intravenous Therapy: Peripheral Vascular Access
    - VUMC Recommendations for Insertion and Management of Central Venous Access Devices

Preventing Catheter-Associated Urinary Tract Infections (CAUTI)

- Follow these guidelines to prevent CAUTIs:
    - Insert catheters only when necessary. Remove them as soon as possible. Assess the need for the catheter daily.
    - Encourage the provider to use the Indwelling Urinary Catheter Nursing-Directed Discontinuation Protocol
    - Use sterile insertion technique to insert the catheter
        - Consider having a second person in the room to assist and ensure sterile technique
    - Perform daily maintenance:
        - Use sterile technique to obtain a urine specimen
        - Keep the urine collection bag below the bladder and off the floor
        - Perform perineal care **every shift** and as needed

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Preventing Ventilator-Associated Events (VAE)

- Patients who are mechanically ventilated are at risk for developing a pneumonia or other serious complications. Listed below are the VAE guidelines to prevent ventilator associated pneumonias and complications:
  - Elevate the head of the patient's bed **30-45 degrees**, if not contraindicated
  - Work with the interdisciplinary team to determine the patient's readiness for a Spontaneous Awakening Trial (SAT) and a Spontaneous Breathing Trial (SBT)
  - Provide preventive treatment for ulcer disease
  - Provide preventive treatment for deep venous thrombosis (DVT)
  - Follow proper hygiene. Perform:
    - Hand hygiene
    - Asepsis during suction
    - Oral care and hypopharyngeal suctioning every 4 hours and as needed
    - Toothbrushing and Chlorhexidine oral rinse every 12 hours and as needed
    - Oral airway removal and oral mucosa is assessed every 24 hours
      - Refer to Mechanical Ventilation SOP

Preventing Falls

- Using the Morse risk assessment scale, follow these guidelines to prevent patient falls:
  - **Low Risk**
    - Check that patient is wearing non-skid footwear
    - Orient patient to surroundings
    - Keep the bed locked and in the lowest position
    - Perform purposeful patient rounding
    - Keep pathways clear
    - Keep call lights, cell phones, and other personal items within patient's reach
    - Make sure there is adequate light in patient's room
  - **Moderate Risk** – In *addition* to the interventions for low risk:
    - Use safe patient handling practices
    - Cluster patient care activities and minimize noise levels to help the patient achieve uninterrupted sleep
    - Monitor the side effects of medications such as blood pressure medications, insulin, narcotics, and sedatives because this can cause dizziness, weakness, and sometimes alter the level of consciousness of a patient
  - **High Risk** – In *addition* to the interventions for low and moderate risk:
    - Establish a toileting schedule with the patient and stay with them during toileting
    - Assist with ambulation
    - Make sure patient is wearing yellow armband and socks
    - Educate patient and family continuously
    - Activate bed/chair alarm
    - Evaluate orthostasis
    - Move patient into room with good visual access
    - Post falls sign on door

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Preventing Hospital-Acquired Pressure Injuries

- Follow these guidelines to prevent pressure injuries:
  - Turn/reposition every 2 hours
  - Use pressure redistribution surfaces
    - i.e. repositioning system, mattress surface settings, chair cushions, heel boots
  - Proper moisture management
  - Consider placement of preventative sacral and heel foam dressings
  - Utilize pressure injury prevention products, i.e. foam dressing, to prevent device-related pressure injuries
  - If MAP system is available on bed, monitor for "red" high pressure spots and reposition as needed
  - Upon a patient's admission/transfer, consider utilizing two staff members to assess the patient's skin for breakdown and document any pressure injuries in eStar
  - Each shift, upon admission/transfer, and change in condition, a Braden score must be documented
  - Consider taking photographs using Haiku app on Mobile Heartbeat phones if skin breakdown noted
  - To reduce risk of pressure injury development in chairs, consider 2-hour increments of chair time and reposition or shift weight every 15 minutes while in a chair
  - Educate and engage patients and families
- Resources:
  - Pressure Injury Prevention and Treatment Guidelines
  - Pressure Injury Stages
  - Adult Urinary and Fecal Incontinence Guidelines
  - Bed Selection Guidelines - Adult

Hand Hygiene

Hand hygiene, also known as handwashing, is an important step in preventing the spread of microorganisms that can cause an infection. At VUMC, staff members are expected to wash their hands every time you enter/leave a patient's room and as needed. Hand hygiene can be done by either using the foam hand cleaner or using soap and water. If you have a sensitivity to the foam, please speak to your leadership team so an alternative hand cleaner can be obtained.

- Hand hygiene is performed before putting on gloves
- For some patient care activities, i.e. patients with C. difficile and norovirus, you must wash hands with soap and water
- Please refer to www.mc.vanderbilt.edu/handhygiene for FAQ and other informational resources
- Avoid dry hands by following these important tips:
  - Use only a dime-sized amount of foam product
  - Use VUMC-approved lotions which are located by sinks in the clinical areas
  - Do not wear gloves longer than necessary

Pain Documentation

- It is best practice to document pain reassessment **within 2 hours** of the pain intervention
  - The 2-hour time window definition is within 16 minutes and 1 hour, 59 minutes of pain intervention

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- Pain reassessments are done based on the route administered and the patient's response, but no more than 2 hours after intervention
- If an intervention has been documented (and the patient is off the unit during the 2- hour assessment window) make an annotation that the patient is off the unit. Make sure to reassess the patient's pain score, once he/she returns to the unit.
- If you document anything in the "Pain Intervention" section (whether medicine or therapeutic approach), a reassessment must be documented in the 2-hour window

Accordion Expanded View All

1m 5m 10m 15m 30m 1h 2h 4h 8h 24h Based

	12/27/17		
	0901	0915	0932
Pain Assessment			
Pain Assessment	0-10		0-10
Pain Score	6		3
Pain Location	head		
Pain Type	aching		
Pain Goal #	3		
Pain Interventions	medication		
Multiple Pain Sites			
Motor block (Bromage)			

- Pain medication should be given according to the order's instructions. Anything outside of the order's parameters requires a new/additional order.
- Medications ordered for pain should be administered with a documented pain score corresponding with the time of administration
- PRN medications ordered for more than one purpose (e.g. Tylenol for pain and/or fever) requires the nurse to annotate in the MAR why the medication was administered
- Medications ordered for pain cannot be administered for anticipated pain during procedures or activity without a specific order
- Medications ordered PRN for pain cannot be administered for sedation purposes

Bar Code Medication Administration (BCMA)

- Ensure the Seven (7) Rights of Medication Administration:
    1. Right Patient
    2. Right Drug
    3. Right Dose
    4. Right Time
    5. Right Route
    6. Right Reason
    7. Right Documentation
- Always scan the patient first, then scan the medication
- If in a procedural/testing area, ask the staff in this department for a Workstation on Wheels or "WOW" so you can perform bar code medication administration

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- If a "WOW" is not available, or during eStar downtime, extra care is warranted to ensure the rights of medication administration
- Refer to eStar Downtime Procedures - Inpatient Units

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