VUH Nursing Quality Guidelines

2024 FY

Preventing Central Line-Associated Bloodstream Infections (CLABSI)

Help to prevent CLABSIs by following these guidelines:

- Place a **swabcap** 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.
- The frequency for sterile dressing changes is dependent on the type of dressing:
  - CHG dressings are changed every 7 days and PRN.
  - Gauze dressings are changed every 2 days and PRN.
- Make sure 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 the new tubing and IV bag before connecting to the new IV site.
- Verify IV tubing is dated/time and labeled
- All patients with a CVC will require a daily CHG bath unless contraindicated.

Date_____	
K-Card: CLABSI Bundle	
Identify a patient with a Central Venous Catheter (CVC)	
	1. Verify daily discussion of line need and functionality • Interview: "When and with who did you last discuss the line?" • Interview: "What education have you provided to your patient/family?
	2. Verify decolonization: • Documentation: "Please show me where the CHG application was documented in the last 24 hours." • Documentation: "If applicable, please show me where nasal decolonization was documented in the last 12 hours."
	3. Verify sterile dressing change: • Observe: Dressing is clean, dry, intact, occlusive and dated (observe full dressing change if possible) • And interview: "What is the process and frequency of a sterile dressing change?" o CHG dressings changed q7 days and PRN o Gauze dressings changed q2 days and PRN o Sterile needleless connectors, extension sets, filters, and stopcocks are replaced with tubing changes and PRN
	4. Verify swab cap use on inactive ports
	5. Verify sterile end cap use on inactive IV tubing
	6. Verify catheter secured to reduce movement or tension o Catheter should be secured with either sutures or securement device
	7. Verify IV tubing is dated/timed and labeled • Interview: "What is the frequency of a tubing change?" o Tubing should be changed every 96 hours for IV solution and med tubing; 24 hours for PN; 12 hours for IV fat emulsion and propofol; 4 hours for blood products
	8. Verify RN scrubs the hub/port 5x around and 5x over the top before accessing

Refer to the following policy and recommendations:

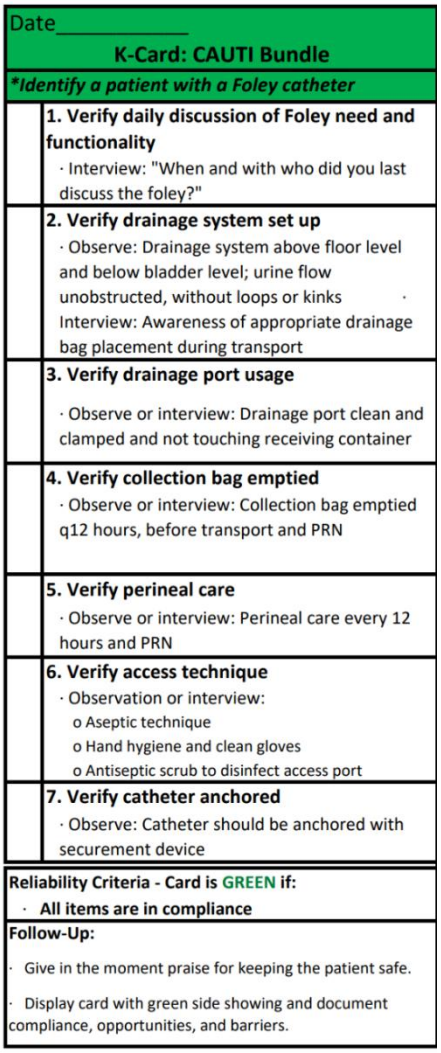
- Intravenous Therapy: Peripheral Vascular Access
- VUMC Recommendations for Insertion and Management of Central Venous Access Devices

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

Preventing Catheter-Associated Urinary Tract Infections (CAUTI)

Follow these guidelines to prevent CAUTIs:

- Foley insertion requires a provider's order
- Assess the need for the foley catheter daily and remove as soon as possible.
- Encourage the provider to use the Indwelling Urinary Catheter Nursing-Directed Discontinuation Protocol
- Use sterile insertion technique to insert the catheter.
  - ANY break in sterile technique or concern for break, STOP and obtain a new foley kit.
  - 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
    - Start at the meatus and clean AWAY from patient
      - Start at insertion site and outwards.
    - Clean the inside of the thighs.
    - Ensure Stat lock is in good condition.
      - Replace if in poor repair or dirty.



Date_____

K-Card: CAUTI Bundle

Identify a patient with a Foley catheter

	1. Verify daily discussion of Foley need and functionality · Interview: "When and with who did you last discuss the foley?"
	2. Verify drainage system set up · Observe: Drainage system above floor level and below bladder level; urine flow unobstructed, without loops or kinks · Interview: Awareness of appropriate drainage bag placement during transport
	3. Verify drainage port usage · Observe or interview: Drainage port clean and clamped and not touching receiving container
	4. Verify collection bag emptied · Observe or interview: Collection bag emptied q12 hours, before transport and PRN
	5. Verify perineal care · Observe or interview: Perineal care every 12 hours and PRN
	6. Verify access technique · Observation or interview: o Aseptic technique o Hand hygiene and clean gloves o Antiseptic scrub to disinfect access port
	7. Verify catheter anchored · Observe: Catheter should be anchored with securement device

Reliability Criteria - Card is GREEN if:

· **All items are in compliance**

Follow-Up:

· Give in the moment praise for keeping the patient safe.

· Display card with green side showing and document compliance, opportunities, and barriers.

Preventing Ventilator-Associated Events (VAE)

Patients who are mechanically ventilated are at risk of developing 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 JFRAT assessment scale, follow these guidelines to prevent patient falls.

- **Low Risk**
- **Moderate Risk**
- **High Risk**

Please see facility specific Fall Prevention SOP for more in-depth details on interventions

- Falls Prevention - Adult v.4 (policytech.com)

If a patient falls, ensure that there is not an immediate danger to the patient and alert the patient's primary nurse as well as the charge nurse.

There will be specific fall documentation, please see facility specific SOP

- Falls Prevention - Adult v.4 (policytech.com)

Date_____

K-Card: Falls Bundle

Utilizing a standardized risk assessment tool, identify a high fall risk patient who is in their room

	1. Verify patient/family received falls education • Interview patient/family: "Has a member of your care team spoken to you about how we're keeping you safe from falling today?"
	2. Verify nurse assists with ambulation and transfers (i.e. to bathroom, bedside commode)
	3. Verify nurse or Care Partner completes targeted toileting • Interview patient/family: "Has someone offered to go with you to the bathroom every couple of hours?"
	4. Observe bed in lowest position with brakes locked
	5. Observe call light within reach of patient or caregiver
	6. Observe bedside table within reach of patient or caregiver
	7. Observe walkway clear of cords, tubing, and extra equipment
	8. Observe high risk sign outside door
	9. Observe yellow non-skid footwear on or readily available • Patient wears non-skid footwear while ambulating or in bed *or* patient has non-skid footwear within reach and states they wear when ambulating
	10. Observe yellow "Fall Risk" arm band on extremity
	11. Observe door is open, if patient unable/unwilling to call for assistance or impulsive
	12. Observe bed or chair alarm on, if patient unable/unwilling to call for assistance or impulsive

Reliability Criteria - Card is GREEN if:

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Follow-Up:

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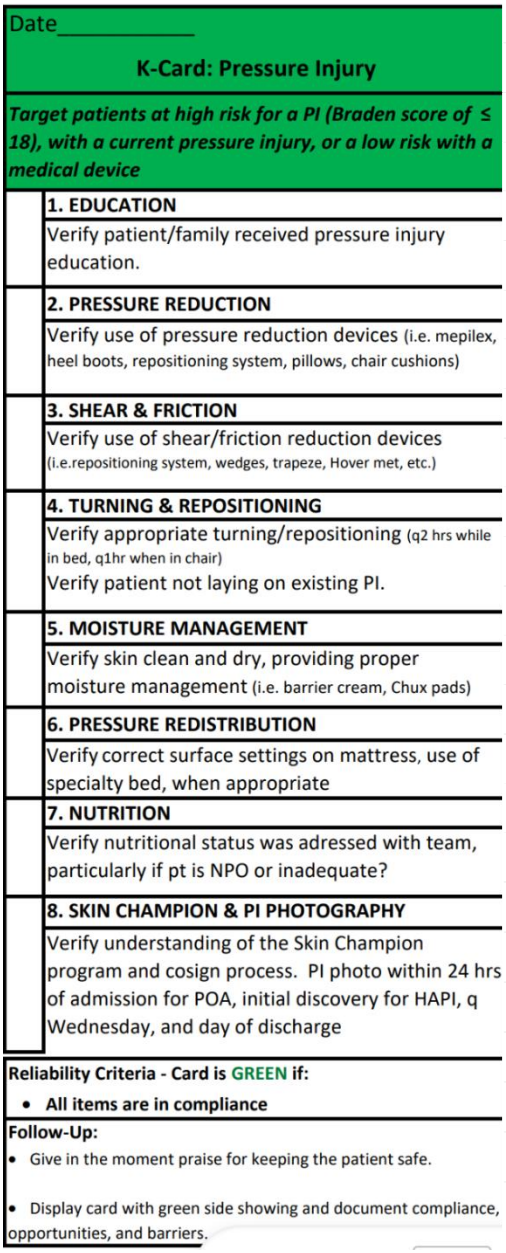
Preventing Hospital-Acquired Pressure Injuries

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



Date_____

K-Card: Pressure Injury

Target patients at high risk for a PI (Braden score of ≤ 18), with a current pressure injury, or a low risk with a medical device

	1. EDUCATION Verify patient/family received pressure injury education.
	2. PRESSURE REDUCTION Verify use of pressure reduction devices (i.e. mepilex, heel boots, repositioning system, pillows, chair cushions)
	3. SHEAR & FRICTION Verify use of shear/friction reduction devices (i.e.repositioning system, wedges, trapeze, Hover met, etc.)
	4. TURNING & REPOSITIONING Verify appropriate turning/repositioning (q2 hrs while in bed, q1hr when in chair) Verify patient not laying on existing PI.
	5. MOISTURE MANAGEMENT Verify skin clean and dry, providing proper moisture management (i.e. barrier cream, Chux pads)
	6. PRESSURE REDISTRIBUTION Verify correct surface settings on mattress, use of specialty bed, when appropriate
	7. NUTRITION Verify nutritional status was adressed with team, particularly if pt is NPO or inadequate?
	8. SKIN CHAMPION & PI PHOTOGRAPHY Verify understanding of the Skin Champion program and cosign process. PI photo within 24 hrs of admission for POA, initial discovery for HAPI, q Wednesday, and day of discharge

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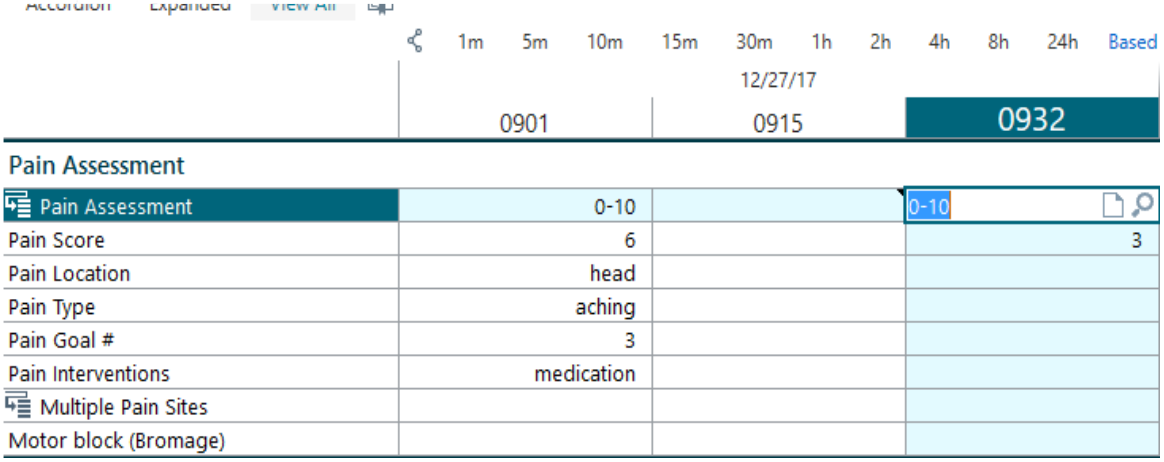
Pain Documentation

- 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.
- 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 the patient 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
- PRN medications CANNOT be given early

ar 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 you are giving now, not a bag that is already hanging
- If in a procedural/testing area, ask the staff in this department for a Workstation on Wheels or "WOW" so you ca perform bar code medication administration

- If a "WOW" is not available, or during eStar downtime, extra care is warranted to ensure the rights of medication administration
    - Ensure mindfulness with medication passes
        - Do not engage in conversations when
            - Pulling medications from Omnicell
            - Preparing medications
            - Administering medications
        - Avoid interruptions and disruptions to prevent medication errors
- Refer to eStar Downtime Procedures - Inpatient Units

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