# PATIENT SAFETY PLAN

**2009**

Submitted by: Maggie Rykowski, RN, MS  Patient Safety Officer

<table>
<thead>
<tr>
<th>INITIATIVE</th>
<th>AIM</th>
<th>TEAM MEMBERS</th>
<th>METHODS/RESPONSIBILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infection Prevention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Ventilator Associated Pneumonia (VAP)</td>
<td>Decrease rate of VAP by 50% overall by June 2010</td>
<td>Lisa Winston, MD, Elaine Dekker, RN, Sue Felt, RN, Mike Jula, Janet Diaz, MD, Francoise Pate, MD, Andre Campbell, MD, Sabra Weiss, RT, Jenny Farr, RN, Sam Jones, RN</td>
<td>Monitor all mechanically ventilated patients for the development of VAP during their hospital stay utilizing the following methods: Record Review of all 4E ICU/5E5R ICU Progress Notes • Computer Data mining from Clinlabs from respirator specimen microbiology cultures • ICU Careview (patients/device days) • ISM (ICU Ventilator Pts/Days specific) • Clinical validation of findings • Rates reported quarterly to Infection Control Committee, NQICC, PIPS and MEC Accomplished through: • Continued implementation of IHI Bundle • Frequent Oral Care • Staff education, increased awareness</td>
</tr>
<tr>
<td>(BEACON Initiative)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Central Venous Catheter Associated Blood Stream Infections (CVC-BSI)</td>
<td>Decrease rate of CVC by 50% overall by June 2010</td>
<td>Lisa Winston, MD, Kitty Mah, RN, Mike Jula, Pierra Wong, CNS, Shirley O’Donnell, RN, Sam James, MD</td>
<td>Monitor for development of CVC-BSI during hospitalization utilizing following methods: • Computer data mining from Clinlabs and ICU Careview • Medical Record review, validate findings through use of standardized criteria. • Rates reported quarterly Infection Control Committee, Accomplished through: • Continued use of IHI Bundle • Staff education regarding site and tubing care, increased awareness.</td>
</tr>
<tr>
<td>(BEACON Initiative)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INITIATIVE</td>
<td>AIM</td>
<td>TEAM MEMBERS</td>
<td>METHODS/RESPONSIBILITIES</td>
</tr>
<tr>
<td>------------</td>
<td>-----</td>
<td>--------------</td>
<td>--------------------------</td>
</tr>
</tbody>
</table>
| C. Central Line Insertion Practice (CLIP) | Aseptic technique will be adhered to for all CVC insertions 100% by Dec 09. | Lisa Winston, MD Kitty Mah, RN Piera Wong, CNS Ken Coelho Mike West, MD | Monitor for compliance by the following:  
  - Observation of proper hand hygiene, use of maximal barrier precautions upon insertion, use of appropriate skin antisepsis and optimal catheter site selection  
  - Utilization of CLIP form as pre-procedure checklist for every CVC insertion.  
  - Rates will be reported monthly to ICC/MEC and quarterly to Critical Care Committee/Infection Control Committee/Medical Executive Committee, NQICC and PIPS.  
Accomplished through:  
  - Collection of completed CLIP tool by provider.  
  - Staff education regarding infection prevention measures. |
| D. Surgical Site Infection (SSI) | A 25% reduction of SSI by December 2009 | Chip Chambers, MD Lawrence Nichols, RN William Chun, RN Elaine Dekker, RN Mike Jula Ocean Berg, RN Mike West, MD Dan Deck, PharmD | Monitor for SSI as a result of selected surgical procedures utilizing the following methods:  
  - Initial identification of patients from ORMIS  
  - Chart review by IC practitioner to determine if criteria is met for SSI  
  - IC practitioner will report findings to attending surgeon and quarterly to the OR, IC and MEC Committees.  
Accomplished through:  
  - Antibiotic timing and selection.  
  - Select one service to pilot. |
<table>
<thead>
<tr>
<th>INITIATIVE</th>
<th>AIM</th>
<th>TEAM MEMBERS</th>
<th>METHODS/RESPONSIBILITIES</th>
</tr>
</thead>
</table>
| E. Hand Hygiene                        | 90% of staff observed will clean hands when required/opportunity presents by December 2009 | Lisa Winston, MD, Elaine Dekker, RN, Kitty Mah, RN IC Liaisons | Monitor for Hand Hygiene will be performed utilizing the following methods:  
  • Infection Control trained observers perform visual surveillance using a standardized checklist. Each observer will document a minimum of 20 observations each month per unit.  
  • Rate will be reported to section staff at meetings and quarterly to PIPS and NQICC.  
  • Areas scoring less than threshold of 85% will have observation frequency increased.  
  Accomplished through:  
  • Random observation  
  • Staff education                                                                 |
| F. Clostridium Difficile (BEACON Initiative) | Decrease rate by 20% by December 2009                               | Lisa Winston, MD, Sue Felt, RN, Elaine Dekker, RN, Kitty Mah, RN Johnson Gong Francisco Saenz Dan Deck, PharmD | Sentinel organism monitoring via Laboratory immediate notification to ordering physician and daily reporting to Infection Control Department.  
  Accomplished through:  
  • Use of contact isolation, proper environmental cleansing by both Nursing and EVS personnel.  
  • Antibiotic utilization review  
  • Report rates monthly to ICC/MEC. Quarterly to BEACON.  
  • If cluster is detected it will be reported immediately to affected area for intervention. CDPH reportable. |
<table>
<thead>
<tr>
<th>INITIATIVE</th>
<th>AIM</th>
<th>TEAM MEMBERS</th>
<th>METHODS/RESPONSIBILITIES</th>
</tr>
</thead>
</table>
| G. MRSA | 90% of all patients from CDPH categories will be swabbed within 24 hours who meet criteria by December 09 | Chip Chambers, MD Elaine Dekker, RN Ana Sampera, RN Susan Illnicki, RN Terry Dentoni, RN Sam Jones, RN Genny Farr, RN Barbara Haller, MD | Monitor for compliance by the following:  
• Nasal swab will be collected as part of the admission process on all ICU and in-patient dialysis patients, patients who have been in a nursing home past 30 days, hospitalized within the last 30 days or hospitalized within the last 30 days.  
• Microbiology will send MRSA Surveillance Nasal Report daily to Infection Control for review.  
• Attending physician will be notified of positive screening cultures. IC staff will be consulted for further management.  
Accomplished through:  
• Collection of nasal swab specimens as per protocol.  
• Monitoring of positive patients.  
• Review of documentation of notification.  
• Report rates monthly to ICC and quarterly to MEC/PIPS |
| H. Acute Myocardial Infarction (AMI) | 100% of patients diagnosed with AMI will receive the evidenced based AHA guideline therapies in the timeframe designated. | Jeff Tabis, MD John Fazio, CNS Genny Farr, RN Paul Koo, RN John Mcgregor, MD | Monitor compliance by the following:  
• Review data on compliance with PCI within 90 minutes of arrival and consistent documentation of smoking cessation counseling.  
• Review completed core measure data collection tool on all AMI cases monthly as available. Accomplished through:  
• Completion of core measure data collection tool.  
• Focused review of PCI cases with CCU nurse manager to facilitate analysis of delays in PCI timing.  
• Report quarterly to PIPS |
<table>
<thead>
<tr>
<th>INITIATIVE</th>
<th>AIM</th>
<th>TEAM MEMBERS</th>
<th>METHODS/RESPONSIBILITIES</th>
</tr>
</thead>
</table>
| I. Anticoagulation Therapy | 100% of patients prescribed anticoagulant therapy will be monitored for potential harm reduction. | Mary Gray, MD  
Will Huen, MD  
Mark Jones, PharmD  
Christina Wang, PharmD  
Paul Koo, RN  
Nancy Parker, RN  
Gloria Garcia-Orme, RN  
Katy Murphy, MD  
Ebi Fiebig, MD  
Janet Kosewic, RN  
Sylvia DeTrinidad | Monitor compliance by the following:  
• Ongoing monitoring for compliance with Anticoagulation therapy protocol by clinical pharmacist. Reported quarterly to MUSS.  
• Review all ADRs and UO’s. Report to MUSS monthly.  
Accomplished through:  
• Review of record and labs by Clinical Pharmacist on all patients prescribed anticoagulation therapy.  
• Monitor adherence to Anticoag protocol and Lab Monitoring policy.  
• Staff education and training guidelines on patient teaching. |
| J. Falls with Injury Prevention Program (BEACON Initiative) | Reduce falls with Injury rate by 50% by June 2010. | Cindy Johnson, CNS  
Peggy Wilson, CNS  
Kathy Ballou, RN  
Bonnie Seaman  
Edgar Pierlussi, MD  
Nam Do, PharmD  
Janet Kosewic, RN | Monitor for reducing falls with injury will be performed using the following methods:  
• Perform thorough assessment of all current falls processes throughout the organization to include acute care, long term care and outpatient.  
• Multidisciplinary task force assembled to monitor the comprehensive hospital-wide program.  
• Reports quarterly to NQICC  
Accomplished through:  
• Monitor falls with injury rate.  
• Conduct post fall multidisciplinary review.  
• Defined staff roles and responsibilities.  
• Hospital-wide policy implementation. |
<table>
<thead>
<tr>
<th>INITIATIVE</th>
<th>AIM</th>
<th>TEAM MEMBERS</th>
<th>METHODS/RESPONSIBILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>K. Hospital Acquired Pressure Ulcers (HAPU)</strong>&lt;br&gt;(BEACON Initiative)</td>
<td>Reduce HAPU (all stages) by 50% by December 2009</td>
<td>Nora Brennan, CNS&lt;br&gt;Ann Goodall, CNS&lt;br&gt;Sheryl Calson, CNS&lt;br&gt;Will Huen, MD&lt;br&gt;Susan Illnicki, RN&lt;br&gt;Ana Sampera, RN&lt;br&gt;Terry Dentoni, RN&lt;br&gt;Lettie Miller, RN&lt;br&gt;Michael Daly, RN&lt;br&gt;Irene Blanlco, RN&lt;br&gt;Pat Carr, RN&lt;br&gt;Kelly Toth, RD</td>
<td>• Evaluate current pressure ulcer management and treatment throughout the organization.&lt;br&gt;• Monitor the pressure ulcer program to ensure coordination and consistency of care of patients that are hospitalized with hospital or community acquired pressure ulcers.&lt;br&gt;• Reports to NQICC quarterly.&lt;br&gt;Accomplished through:&lt;br&gt;• Use of preventive measures such as skin assessment, Braden Scale, skin protection to prevent breakdown.&lt;br&gt;• Conduct weekly skin rounds and completion of log book.&lt;br&gt;• Conduct staff education on assessment and documentation.&lt;br&gt;• Participation in quality pressure ulcer prevalence study to benchmark with other hospitals.</td>
</tr>
<tr>
<td><strong>L. Influenza and Pneumococcal Disease in Older Adults (NPSG)</strong></td>
<td>Reduce morbidity and mortality from influenza and pneumococcal by screening and vaccination of all eligible patients by December 2009</td>
<td>Nela Ponferrada, RN&lt;br&gt;Christine Martin, RN&lt;br&gt;Lisa Winston, MD&lt;br&gt;Julie Russell ParmD&lt;br&gt;Susan Illnicki, RN&lt;br&gt;Winona Mindolovich&lt;br&gt;Roland Pickens&lt;br&gt;Gloria Garcia-Orme&lt;br&gt;Nancy Parker</td>
<td>Conduct an evaluation of the current monitoring program to assess compliance of immunity to Influenza and Pneumococcal virus.&lt;br&gt;Report to NQICC annually.&lt;br&gt;Accomplished through:&lt;br&gt;• Screening of eligible patients.&lt;br&gt;• Vaccination of eligible patients.&lt;br&gt;• Vaccination of Health Care Workers.</td>
</tr>
<tr>
<td>INITIATIVE</td>
<td>AIM</td>
<td>TEAM MEMBERS</td>
<td>METHODS/RESPONSIBILITIES</td>
</tr>
<tr>
<td>------------</td>
<td>-----</td>
<td>--------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>M. Just Culture</td>
<td>Incorporate a Just Culture framework throughout the organization by December 2010</td>
<td>Maggie Rykowski, RN Jay Kloo, RN Troy Williams, RN Sharon Wicher, RN Todd May, MD (Need to identify reps from Labor, Pharmacy, Outpatient Services, Support Services, Dean’s Office)</td>
<td>Create a task force charged with assessing the organizational gaps and develop a framework proposal and guide for implementation by December 2009. Key stakeholders attend a California Patient Safety Action Coalition (CAPSAC) Just Culture training for Health Care staff. Propose concept of Just Culture to members of Management Forum, NEC and MEC Perform a gap analysis to identify current culture and necessary steps to implementation. Report to Quality Council annually Accomplished through: • Hospital-wide staff education on Just Culture concepts. • Development and implementation of a tool to investigate Incidence. • Review NRC-Pickey survey results of patient experience.</td>
</tr>
<tr>
<td>N. Medical Emergency Response Team (MERT)</td>
<td>Reduce Code Blue events outside of the ICU by deploying the MERT at the first sign of patient decline.</td>
<td>Leslie Dubbin, RN Jennie Farr, RN Sam Jones, RN Sabra Weiss, RT Julin Tang, MD</td>
<td>Monitor Code Blue and MERT activations and report to Code Blue Committee. Conduct rounds for early identification of possible worsening conditions. Accomplished through: • Staff training and awareness. • Analysis of data.</td>
</tr>
<tr>
<td>INITIATIVE</td>
<td>AIM</td>
<td>TEAM MEMBERS</td>
<td>METHODS/RESPONSIBILITIES</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>O. Suicide Risk</td>
<td>100% of all non-psychiatric admissions are screened for suicide risk by December 2009</td>
<td>Mark Leary, MD</td>
<td>Conduct a hospital-wide assessment of the Suicide and Psychosocial tool to measure effectiveness.</td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td>Grad Green RN</td>
<td>Using a standardized tool, the RN will screen and document suicide risk assessment on all patients that present with identified criteria.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Janet Kosewic, RN</td>
<td>Reports to Quality Council and PIPS annually.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Troy Williams, RN</td>
<td>Accomplished through:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Irin Blanco, RN</td>
<td>• Audit of encounter forms, medical record and admission database.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ana Sampera, RN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kathryn Fowler, RN</td>
<td></td>
</tr>
</tbody>
</table>
