State of Nebraska Transition Grant

Patient Safety for the New Graduate Registered Nurse
Education Module

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Title: Patient Safety

Learning Objectives:

Upon completion of this education module, the new graduate registered nurse will:

**Infection Control**
1. Identify sources of infection for the hospitalized patient.
2. List methods of controlling transmission of infection-causing agents to patients.
3. Verbalize understanding of the facility’s policies on infection control applicable to new nurse’s unit.
4. Demonstrate proper hand washing technique
5. Verbalize when to wash hands versus use approved hand gel.

**Skin Care**
1. Identify common sources of skin tears for hospitalized patients.
2. List methods of protecting skin of hospitalized patients from breakdown.
3. Identify patients at risk for skin breakdown.
4. Complete a Braden Scale skin assessment tool on several patients.
5. Identify skin care resources within the facility where the new nurse works.

**Fall Prevention and Patient Safety**
1. Complete a fall risk assessment on several patients.
2. Review a suicide assessment tool, if appropriate to the facility.
3. Identify environmental hazards within a patient’s room that increase a patient’s risk for falling.
4. Identify physical or medical factors that contribute to a patient’s risk for falling.
5. Identify interventions and resources to decrease a patient’s risk for falling.
6. Discuss patient identification procedures used within the clinical setting, to include any unit specific alarm systems.
7. Describe hospital-wide procedures related to fire alarms, weather alerts, or other threat-containment.

**Medication Errors**
1. List and demonstrate the 6 rights of medication administration.
2. Demonstrate understanding of use of the medication administration system.
3. Discuss how medication administration systems prevent medication errors and promote a climate of safety for the patient and nursing staff.
4. Identify methods nurses erroneously use to short cut a medication administration system.
5. Verbalize methods to decrease medication administration errors.
6. Utilize interventions and resources within the facility to decrease medication errors (i.e., medication administration safety zone).

**Communication**
1. Utilize SBAR when handing patient off to another nurse.
2. Utilize SBAR when calling a physician related to a change in a patient’s status.
3. Obtain orders to admit or discharge a patient. Integrate the read-back procedure when obtaining these orders.
4. Participate in medication reconciliation upon admission of discharge of a client.
5. Utilize *Ticket To Ride* or similar system when sending a patient to radiology, OR, dialysis, or other area for testing (when handing off to non-nurse personnel).
6. Demonstrate ability to perform a bedside report to personnel on the next shift.

**Rapid Response System**
1. Describe the purpose of the team, the team members, and their activities.
2. Verbalize parameters used to call a rapid response team to a patient’s bedside.
3. Role play calling the rapid response team with the preceptor, based on a case scenario described by the preceptor.
4. Demonstrate ability to give informed report to rapid response team when they arrive at bedside.

**Interactive Exercises:**

1. Visit [http://www.cdc.gov/features/PatientSafety/](http://www.cdc.gov/features/PatientSafety/) to review the Center for Disease Control’s recommendation to patients to keep themselves safe during hospitalization: *Patient Safety: 10 Things You Can Do to Be a Safe Patient*. Click on and review the links within the 10 items.

2. Visit [http://www.ccforpatientsafety.org/Patient-Safety-Solutions/](http://www.ccforpatientsafety.org/Patient-Safety-Solutions/) to review the Joint Commission’s *Patient Safety Solutions*. Click on and review the links within the 10 items.

3. Read: *Shift workers give sleep short shift* (Fuller, 2010). See reference below. If present, visit with sleep lab personnel at facility about healthy sleep habits. Conduct a self-assessment of sleep habits if possible. Review and discuss article with preceptor.

4. Read: *Engaging the patient in handoff communication at the bedside*, (Grant & Coltello, 2009), and *Improving handoff communication* (Mascioli, Laskowski-Jones, Urban & Moran, 2009). See references below. Discuss the importance of handoff communication with preceptor. Utilize interventions learned when handing off patient care.

5. Visit [http://whynotthebest.org/contents/view/40](http://whynotthebest.org/contents/view/40) and click on the PDF version of the case study. Review and look for interventions nurses used to increase the safety of their patients. This section also has improvement tools and more case studies regarding patient safety. After reading and reviewing tools, debrief with preceptor about methods to use for own practice.

6. Conduct a safety assessment of the new nurse’s unit. A sample of a checklist is included within this module (Appendix A) and may be altered according to the needs of the unit. The new nurse shall use the checklist to evaluate possible safety hazards within patient rooms, in the hall, at the nurses’ station, in the medication room, etc. This is meant to increase the awareness of the safety issues of the new nurse as well as other healthcare team members. After conducting the assessment and making corrections, the new nurse and the preceptor should debrief about the activity.

7. Utilize several resources to increase knowledge and awareness of how medication errors occur.
   a. Nurse journals are a valuable resource. Suggested references are listed below. Discuss types of errors and how to prevent them with preceptor.
b. Contact the hospital’s Risk Management manager. This can be a valuable resource for errors made in the past and lessons learned. They may have examples of previous root cause analysis done on errors.

c. Subscribe to (if not already available at medical center) ISMP Medication Safety Alert! Nurse Advise-ERR (link provided in Suggested References).

8. Utilize resources to increase knowledge and awareness of rapid response teams.
   a. Read Rapid response teams: The case for early intervention (see reference below).
   b. Verbalize understanding of facility’s policy for rapid response system.
   c. While in orientation role, if able, respond with the rapid response team 3-5 times. Report back and discuss with preceptor what initiated the call, what was given in report to the team, and the team’s response. What was the patient outcome?

9. Utilize resources to increase knowledge and awareness of prevention of skin breakdown.
   a. Nursing journal articles such as Blaney, 2010 and Meehan, 2009 (see references below).
   b. Research sources of information within the facility related to prevention of skin breakdown (i.e., standard order sets, care plans, wound-ostomy nurse, and internet resources).
   c. Contact the Wound Care Clinic and arrange to spend time with a Wound Care nurse either in the clinic or as part of the facility activity and discuss her role in skin care and prevention.

10. Utilize resources to increase knowledge and awareness of preventing transmission of infection to the hospitalized patient.
    a. If possible, discuss ways to prevent infection transmission in the hospitalized patient with the staff in the infection control office at the facility.
    b. Read and review the following web site for information on catheter associated UTIs, http://www.accelacomm.com/microsite/hospital_acquired_uti/index.html Scroll to the bottom of the screen where there are several articles about prevention of catheter associated UTIs. Read at least two articles to earn the CEUs.
    c. Utilize nursing journals to research other common methods and sources of infection for the unit the new nurse is hired to (VAP, central line infection, etc.).
    d. Discuss the above with the infection control nurse or preceptor.
References


Suggested Websites


Institute for Safe Medication Practices http://ismp.org/

Joint Commission http://www.jointcommission.org/patientsafety/

Nursing Center
http://www.accelacomm.com/microsite/hospital_acquired_uti/index.html

Why Not the Best
http://whynotthebest.org/
Appendix A

Nursing Unit Safety Assessment Check List

*Add or delete list items depending on individual units.

<table>
<thead>
<tr>
<th>Hallway</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the hallway clear of equipment or obstacles (i.e., bags of dirty laundry)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the hallways lit brightly enough for patients to see when walking?</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurses’ Station</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is equipment in working order (i.e., no broken chairs, frayed electrical cords, etc.)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Room</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the floor clear of clutter?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the floor dry or marked with caution signs if just cleaned?</td>
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</tr>
<tr>
<td>Is the lighting adequate in order to read medication labels?</td>
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<td></td>
</tr>
<tr>
<td>Is equipment in working order (i.e., no frayed electrical cords, etc.)?</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Patient Rooms</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If patient is in bed, are two side rails up?</td>
<td></td>
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<tr>
<td>Is the call light within the patient’s reach?</td>
<td></td>
<td></td>
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<tr>
<td>Does the patient have on or have access to their glasses and/or hearing aids?</td>
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<td></td>
</tr>
<tr>
<td>Has the patient’s fall risk score been done? If so, are interventions in place to prevent a fall if they are at risk?</td>
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<td></td>
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<tr>
<td>Does the patient have an identification band on?</td>
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<td></td>
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<tr>
<td>Does the patient have an allergy band on?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have any other factors that would require other colored bands? (i.e., purple band to indicate not to use an extremity)?</td>
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<td></td>
</tr>
<tr>
<td>Is equipment in working order (i.e., no frayed cords)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are electrical cords safely stored so patient cannot trip over them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have non-skid slippers or shoes to walk in?</td>
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<td></td>
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<tr>
<td>If IV tubing is present, is it marked for expiration?</td>
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<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Is hand gel, soap, and paper towels available for use?</td>
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<td></td>
</tr>
<tr>
<td>Are garbage cans overflowing with garbage?</td>
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<td></td>
</tr>
</tbody>
</table>

Correct items as seen and debrief with preceptor when activity complete