

THE ADVOCATE!

"Keeping you in touch with our collective critical care team"

Weekly Medication Safety Huddles

The Problem: The literature identifies that ICU patients experience on average 1.7 errors per day and 78% of these are medication related.¹ Given the medical complexity of the critically ill patient and their limited ability to compensate for these errors, life threatening consequences are probable.² It has been estimated that 50 to 96% of errors are under-reported. Barriers to reporting are many and include fear, mistrust, workload and staffing levels.³

The Solution: In the spring of 2015, we re-established the practice of Weekly Medication Safety Huddles, a short briefing creating an opportunity to share information about actual or potential medication safety issues. We plan to 'huddle' every Tuesday at 1415, recognizing the timing needs to be flexible to accommodate the unit's needs. Participants include any staff working that shift, with the nurses and pharmacists being essential. Other members of the team are welcome; when others including physicians and respiratory therapists join, the discussions take on a new depth.

Weekly Huddles Minutes are made available to all staff, and circulated between ICUs and to the Critical Care Medication Safety Working Group. Each quarter, we review all Minutes to ensure there has been follow-up. Follow-up is documented and circulated to all staff.

Evaluation: This spring, we completed a qualitative survey evaluation of the Medication Safety Huddles. The evaluation confirmed the positive benefits of this very simple intervention.



Knowledge / Education

"Increased awareness of new or old changes with medications"

"Discover latest information regarding a medication or its delivery"

Contribution to Positive Patient Safety Culture

"Actual problems are discussed and frequently real solutions are determined"

"Promotion of a safe environment for error discussion and identification for near misses"

Team Building with Open Communication

"Creating a forum for communication between disciplines fostering relationships and promoting teamwork"

"Chance to discuss things that aren't always discussed"

Foster Accountability

"more responsibility for follow up with issues since we have minutes distributed and things brought forth to other committees to review"

Our Actions based on Evaluation

- ✓ Continue with set day and time early in week. Remain flexible to patient care needs.
- ✓ Charge Nurse & URN help get the word out early in shift.
- ✓ Encourage use of the notebook in both units to add topics for discussion.
- ✓ Remind staff that minutes are available on both units, with URN helping to keep binder up-to-date.
- ✓ Promote Huddles with physicians & other members of team.

In addition to the local success in making the Weekly Medication Safety Huddles part of our practice, a poster was submitted to the national Critical Care Nurses conference. We were awarded the CACCN / Sage Products Poster Bursary, which is presented to a poster with a focus on the prevention of complications or deleterious impacts of critical illness hospitalization.

Congratulations to ALL of our nurses and pharmacists making this SIMPLE solution a BIG success.

1. Moya, Camire, Stelfox. Clinical review: Medication errors in critical care. *Critical Care* 2008;12:208

2. Kekkas, Karga, Lemonidou, Aretha & Karanikolas. Medication errors in critically ill adults: A review of direct observation evidence. *American Journal of Critical Care* 2011;20:(1)36-44.

3. Hartnell, MacKinnon, Sketris & Fleming. Identifying, understanding and overcoming barriers to medication error reporting in hospitals: a focus group study. *BMJ Qual Saf.* 2012 May;21(5):361-8.



Background: Accreditation Canada requires all organizations to provide staff with an opportunity to assess their workplace and patient safety culture. Recently, our staff completed the Worklife Pulse (WLP) Tool and the Canadian Patient Safety Culture (PSC) Survey. The PSC Tool is designed to provide insight into perceptions of patient safety, create awareness of areas of strength and areas of improvement, and provide a way to assess the impact of organizational change. The WLP Survey is designed to monitor key worklife environment factors and outcomes, and to identify strengths and gaps in the work environment (Accreditation Canada, 2013).

Reporting: Results are reported as 'green', 'yellow' or 'red'. 'Green' is a favorable response of 75% or greater, 'yellow' is a favorable response of 50-75%, and 'red' is less than 50%.

NSHA Results: May 2016 marked the first time the NSHA completed the PSC and WLP. Across the NSHA, there were 4620 responses to the PSC (20% response rate), and 5382 responses to the WLP (23% response rate). For the WLP, the majority of flags were green and yellow. All three criteria related to co-workers received green flags. There were 2 red flags in the categories of the organization's senior management (1 red, 3 yellow flags) and employee's overall experience (1 red, 1 yellow, 3 green). For the PSC, the majority of flags were yellow. Themes of a unit learning culture (3 of 4 criteria green) and having an easy way to report patient safety incidents received green flags. There were 3 red flags in the PSC, all related to perceived job repercussions related to patient safety incidents. Results have been reviewed with many lenses, and action plans are being developed at the NSHA, zone, program, and unit/team level.

3A and 5.2 Areas of Weakness:

The most concerning areas of weakness relate to the broader organization and senior leadership. These red flags relate to communication, commitment to high quality care, commitment to a safe and health workplace, actions to prevent violence and abuse, and overall rating as a place to work. The overall organizational grade on patient safety is red.

3A and 5.2 Areas of Strength:

In comparison to the 2013 results, we have seen a broad-based improvement in unit-level patient safety indicators. All indicators of 'unit learning culture' are green flags. Overall, indicators of team-level 'open communication' are positive. The overall unit grade on patient safety is a yellow in both units, improved from red in 2013.

Broad-based indicators reflect that 3A and 5.2 are favourable places to work. All indicators strongly reflect the sense of 'team' in these clinical settings. Results are favourable within the 'your job' dimension & within the 'your immediate supervisor' dimension.

Overall the 'Unit Grade' reflecting quality of patient care, and overall job satisfaction are 'green-flagged' in both units.

Our Quality Team and Leadership has developed a **Plan for Improvement**. Please speak with Sarah, Volker, Cynthia, Tricia or Karen for more information. Here are a few examples of priorities:

- Continue to support the unit learning culture, and 'culture of safety'. Examples include continuing with the weekly Medication Safety Huddles and the Critical Care Medication Safety Group.
- Support positive and collegial interdisciplinary team function. Examples of actions include opportunities such as Medication Safety Huddles, M & M Rounds and Grand Rounds, and Nursing Practice Council events designed by frontline staff. As well, we will move forward with the development of a plan to implement weekly unit-based education / simulation sessions.
- Work to ensure safe environments free from violence and abuse. We need to gain a better understanding of safety needs through an upcoming staff survey, so that actions are effective and specific. One action already moving forward is the provision of 'Ad Hoc Incident Review Training' ('debrief' training) for some of our team. As well, we are working with Occupational Health to implement a new user-friendly process to support all 3A and 5.2 staff to have annual Tb testing.
- Recognize frontline staff's input into safe patient care and a positive workplace. Continue to support staff involvement in unit-level quality improvement, recognizing their knowledge and expertise. Seek opportunities to reward efforts and support career development. Examples include unit-level champions for QI projects; staff development through the URN role; supporting staff to present both internally and externally; and nominating staff for recognition both organizationally and professionally.
- Support building of organizational trust by facilitating two-way communication about plans and processes in the evolving NSHA. We recommend a routine of communication from the Provincial Senior Director of Critical Care, Director of Critical Care, and the Department Head. Examples include direct emails to staff, Newsletter publications and 'QEI Critical Care Town Hall' meetings. We also will work to support consistent use of the patient safety reporting system (SIMS) and the staff safety line (SAFE line).



Leadership Corner: Introducing Debbie Hutchings



Debbie Hutchings is currently the Health Services Director for Heart Health and Critical Care within the Central Zone of the Nova Scotia Health Authority. A nursing graduate and native of Newfoundland, Debbie has held clinical and leadership positions in Critical Care, Emergency, Ambulatory Care and Paediatric Cardiology. A strategic and transformational health care leader, Debbie has more than 25 years experience in health care leadership, health care planning and change management. Debbie holds a Bachelor's Degree in Health Administration and was a graduate in the Health Science Administration Program from the Canadian School of Management. She was the recipient of the Athabasca Governing Council Scholarship in the Masters of Health Studies graduation class.

As a former Critical Care Nurse, Debbie understands your workplace challenges and appreciates the exceptional team work you do delivering quality and safe patient care to our critically ill patients. Debbie looks forward with optimism as we continue Clinical Services Planning for Critical Care for the Central Zone as well as provincially. She welcomes future opportunities to discuss all aspects of Critical Care with you. Her door is always open!

Interpretation and Language Services

As reviewed in our April 2016 newsletter, communication with families is an essential component of care. However, many patients and their families arrive in our ICUs, sick and scared... and unable to speak or communicate in English, which is the dominant language spoken in our units. This barrier can have a very negative impact on both patient care (actual and perceived) and our ability to appropriately demonstrate empathy and compassion during a time of crisis.

The NSHA "Interpretation Policy" states that: "the right to interpretation, at no cost to the patient flows from ... (NSHA's) responsibilities that are inherent in legislation, agreements and guidelines such as the French Language Services Act, the Canada Health Act, and the Nova Scotia Provincial Government's Cultural Competence Guidelines for the delivery of Primary Health Care." As such, a number of services are offered.

Face-to-Face: This service, provided by NSIS (Nova Scotia Interpreting Services), offers face-to-face interpretation in over 40 languages including: Arabic, Bosnian, Cantonese, Croatian, Farsi, French, German, Greek, Italian, Korean, Mandarin, Nepali, Russian, Spanish, Swahili, Vietnamese, and many more. This service can be accessed at 902-425-5532.

Telephone-Based: Another option is the "Language Line Phone", supporting a 3-way interpreter conversation. It links with a confidential, medically certified interpreter service, and is available 24 hours a day. Information on how to access can be found on the intranet, under "I", "Interpreter Services". This can be accessed using a typical phone in the ICU, or by using a "Language Line Phone", through Interpreter Services. For Central Zone our Language Line number is 1-888-898-4524

American Sign Language (ASL): Additionally, services can be accessed for ASL weekly, Monday to Friday, 8:30am – 4:30pm at 902-429-5752. After 4:30 PM and on weekends and holidays, this service can be accessed by calling a pager, at 902-498-1198.

Mi'kmaq interpreters: these services can be accessed by calling 902-453-9358 or paging 902-458-9871.



A Personal Anecdote from Dr. Sarah McMullen: I can attest to the accessibility and utility of the Interpretation Services. Recently, I cared for a patient and family that had recently arrived in Canada from the Middle East. The patient was gravely ill. Care was complicated by the fact that the patient and her husband only spoke a dialect of the Arabic language - and that the patient herself was intubated, sedated and could not communicate at all. Fortunately, one of the residents was familiar with the Interpretation services and recommended we contact them. Interpretation services were of immense help; on several occasions we had face-to-face Interpreters present and translating what were at times very difficult conversations; they did this with empathy and professionalism. We also used the telephone translation services several times, as well. Truly, in this situation, the staff of the Interpretation services were indispensable to our being able to provide timely care and communication to a family in need of care and communication.

THANK YOU & BEST WISHES!

Oh Behalf of all of Critical Care we want to thank **Lisa Julien** for her long time support of the research program. Lisa has moved on to supporting the neurosurgery research program. We look forward to continuing our work with Lisa in this new capacity.

Organ Donation

A report released nationally by Canadian Blood Services in September entitled *Organ Donation and Transplantation in Canada: System Progress Report 2006–2015* included statistics that indicated that Nova Scotia (Critical Care Organ Donation program at the QEII) had more organ donations per million population from deceased individuals than any other province last year. In fact nationally, Nova Scotia has consistently had the highest donor per million rate over the last 5 years. Moreover, our program is on track to further increase its donor per million rate above last year's and maintain its national standing as the highest donor per million rate program in the country.

Further to this, Nova Scotia has the highest intent to donate rate in Canada, with 52% of Nova Scotians registered on their health cards to give the gift of life.

The Multi-Organ Transplant Program, based at the QEII, serves all of Atlantic Canada. In 2015, the program was responsible for 109 transplants, with recipients coming from all four of the region's provinces.

Team Broken Earth was initially formed to support Haiti after the 2010 earthquake. At that time, it was quickly identified that a sustained medical relief effort was needed, resulting in a commitment to Haitian missions. We are very proud that a group of our ICU nurses are joining the Team Broken Earth force later this fall. For information about supporting the mission please speak with Rachel Steeves, Audrey Gallant, Gillian Johnston, Ellen Walsh, or Elinor Kelly

Changes to our Critical Care Family: Welcomes! & Thank You's!

We have had a few new hires and additions to our ICU family since our last edition. WELCOME!

- **3A ICU** welcomes new novice nurses: Dennis Trainor, Melanie Harding, and Jennifer Hartley as well as three new hires: Diane Wilson RN, Tammy Bona CTA, & Angela Wilson CTA.
- **5.2 ICU** welcomes new novice nurses: Kayla Withrow and Brittany Belzevick. In addition the 5.2 family has welcomed two new hires: Jennifer Lawless and Kaitlyn Landry as CTA's.
- **RT Group** is happy to welcome their new hire Alicia D'Leon.
- **Pharmacy Group** has welcomed pharmacist Emma Reid to their team.

With the coming of new staff we have seen some amazing members of our family leave. A BIG thank you for your dedication and hard work! You will be missed!!

- **3A Goodbyes:** Nora Reyno Smith who is leaving ICU for a new experience
- **5.2 Goodbyes:** Ai McQuade who has moved to PACU at the HI.
- **RT Goodbyes:** Marlene Heath, Laura Burke, and Tara Planetta



DYNAMICS!

Each year, the Canadian Association of Critical Care Nurses hosts a national conference called 'Dynamics'. This September, Dynamics was held in Charlottetown PEI, and we took advantage of it being so close! Our ICUs:

- had 10 nurses in attendance
- won the CACCN / Sage Products Poster Bursary
- provided two oral presentations (VG flood and aftermath; early mobility)
- presented a poster about our Medication Safety Huddles



Kudos to Colleagues!

5.2 is excited to introduce you to Tom. Tom was a patient on 5.2 during the winter and early spring of 2016. He came in with hypoxic respiratory failure that was felt to be secondary to Influenza. Within 48 hours Tom was on ECMO and remained on ECMO for a total of 41 days! Tom was eventually discharged to his home hospital at the end of April. Tom's discharge is truly one to celebrate! All of the team contributed to his successful improvements and eventual discharge. We were all excited to have him visit us in August with his dad; he has been making gains every day and at that time was requiring the assist of a cane but has been otherwise feeling well.

"The nice thing about teamwork is that you always have others on your side"

~ Margaret Carty ~



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