Providence
Mission Hospital

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

2022 Nursing Annual Report



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Dear Nursing Family,

As we reflect on the last year, we are reminded of the 2022 theme for National Nurses Week: "Nurses Make a Difference!" In so many remarkable ways, across both our campuses, our nurses demonstrate again and again the incredible difference they make in the lives of our patients, their families and in lives of colleagues.

When we think about how our dedicated nurses attend to the needs of our patients, it reminds us of the devotion of the Sisters of St. Joseph of Orange and the Sisters of Providence. Through faith, foresight and flexibility, these courageous women religious created a legacy of service to the poor and vulnerable. It is inspiring to see our nurses follow in the footsteps of our dear Sisters to care for our community when they need us most.

This annual report is a tribute to your dedication and commitment!

- In celebration of our fourth Magnet re-designation, a team of nurses participated in the 2022 Magnet Conference. Thanks to the generosity of a community member, 21 nurses attended the conference and walked in the designation ceremony.
- Our cancer program received accreditation from the National Accreditation Program for Rectal Cancer (NAPRC). Providence Mission Hospital is one of only seven hospitals in California and among only 25 in the U.S. to earn this impressive recognition.
- We were recognized with the Women's Choice Award for America's Best Hospitals for obstetrics, emergency care, heart care, comprehensive breast care, stroke care, minimally invasive surgery, mammogram imaging and women's services. Providence Mission Hospital was also ranked among the top 100 hospitals in the nation for patient experience.
- Cal Hospital Compare recognized Mission as a designated Opioid Care Honor Roll recipient for our commitment to the implementation of evidence-based practices to address the opioid crisis.
- The American Heart Association/American Stroke Association honored us with the Get With the Guidelines®—Stroke Gold Plus Honor Roll Elite Plus Award, which recognizes our commitment to adhere to target measures and provide prompt intervention.
- *Newsweek* named Mission as one of the World's Best Hospitals in 2022 and the No. 1 hospital in Orange County for the second consecutive year. Mission was ranked as No. 14 in California and No. 100 in the United States. These distinctions are based on patient satisfaction surveys, patient safety data and quality treatment measures.
- *Newsweek* also honored Providence Mission Hospital as one of the Best Maternity Hospitals in the country and awarded us the highest score possible — five ribbons.
- *U.S. News and World Report* ranked us as the No. 1 hospital in South Orange County, No. 7 in the Los Angeles/Orange County region and No. 15 in the state of California. Two of our programs were recognized nationally:
    - Orthopedic — No. 34 in the country and No. 8 in California
    - ARU/Rehabilitation — No. 38 in the country and No. 4 in the state
- Healthgrades® recognized Mission as a Five-Star Recipient in the treatment of sepsis, bowel obstruction, GI bleed and heart failure and we earned Excellence Awards for cardiac surgery, gastrointestinal care and surgery. Mission was honored as one of America's 100 Best Hospitals for gastrointestinal surgery.
- ARU earned CARF re-accreditation for Comprehensive Rehabilitation and the following specialties: brain injury (both in-patient and outpatient), stroke and cancer.

And finally, we will remember 2022 as the year that our integrated market master plan was approved by the Providence system board and the Sponsors Council. The master plan includes a new patient tower and ambulatory surgery center on the Mission Viejo campus and the development of new multi-specialty health centers in San Clemente and Rancho Mission Viejo. This plan represents a $712 million investment by Providence and really demonstrates the leading role that Mission plays in the Providence family of 52 hospitals.

This list represents just a few of the many recognitions we received and the accomplishments we achieved, thanks to your passion and devotion.

Thank you for truly following in the footsteps of our dear Sisters and for serving as expressions of God's healing love.

Seth R. Teigen, FACHE
Chief Executive

Jennifer Cord, RN, MBA, DNP, NE-BC
Chief Nursing Officer

Advanced Practice Council Accomplishments 2022

2022 ANNUAL GOALS, PROGRESS AND RESULTS

1. **Support RN certification advancement at Providence Mission Hospital by providing review courses or access to review courses in two specialties annually.**

    - Two Stroke Certification Review Courses.
    - Support and dissemination of certification resources through the Providence online system library resources. (i.e., CCRN, PCCN, CEN, Medsurg)
    - Support and dissemination of the review courses that were purchased by professional education. (MedEd discounted certification review courses)

2. **Support the promotion of qualified CNIII and CNIV annually.**

    - Reinvigorated clinical ladder program and there are now 33 nurses on the clinical ladder journey.
    - Mentoring/coaching several individuals on their clinical ladder journey and completing IRB applications.

3. **Support Magnet re-designation with EBP projects and research, collecting statistics, and writing two sources of evidence each annually.**

    - APN wrote and edited many Magnet sources of evidence.
    - APN assisted with preparing for the third Magnet recertification.
    - APN facilitated/lead several Evidenced-based practice and quality improvement projects. (i.e., Skin care prevention in patient undergoing prone therapy, prone therapy in medical surgical patients, automated and manual prone therapy in critically ill COVID-19 patients, COVID-19 alternative staffing guidelines, Preventing Aspiration pneumonia)

4. **Support Shared Governance councils and members by providing education and mentoring annually.**

- House Wide Practice Council (Mary Kay Bader, Jill Donaldson, Teresa Wavra)
- House Wide Education (June Melford)
- House Wide Quality (June Melford)
- Research Council (Jill Donaldson)
- Coordinating Council (Mary Kay Bader, Jill Donaldson, June Melford, Teresa Wavra)

OTHER ACCOMPLISHMENTS AND NOTABLE EVENTS BY COUNCIL:

- Evidence-based Practice Post Cardiac Arrest Clinical Guidelines (Mary Kay Bader, Teresa Wavra)
- Chair of ICU Liberation at Mission (Mary Kay Bader)
- Provide advanced Disease Education and Advanced clinical competency Education for Critical Care (Mary Kay Bader, Teresa Wavra)
- Evidence-based quality improvement project – Implementing a Clinical Decision algorithm to Improve Fluid Resuscitation in Sepsis (Teresa Wavra)
- Chair of Neurotrauma, Neurocritical care subsection meeting (Mary Kay Bader)
- Support/facilitate Hospital Acquired Infection Performance Improvement Committee (Jill Donaldson, June Melford)
- Co-lead COVID Task Force with medical director of critical care (Mary Kay Bader)
- Chair of VTE-PI team (Jill Donaldson)
- Co-chair Providence Cardiopulmonary Clinical Decision Team (Teresa Wavra)
- Chair Pain Committee (Jill Donaldson)
- Chair Restraint Committee (Jill Donaldson)
- Chair the Skin Care Committee (June Melford)
- Co-chair Resuscitation Committee (Mary Kay Bader)
- Provided on-line education for transition to EPIC electronic medical record (Mary Kay Bader)
- Support Interdisciplinary Practice Council (Teresa Wavra)
- Support Health System Institutional Review Board (Teresa Wavra)

Research Council Accomplishments 2022

2022 ANNUAL GOALS, PROGRESS AND RESULTS

1. **Provided forum for internal MSN/DnP dissemination and scholarly presentations of nursing research and quality improvement**

- **Anne Lawson DnP, RN** — Educating nurses on advance directives
- **Teresa Wavra DnP, RN** — Implementation of a clinical decision algorithm to improve fluid resuscitation in sepsis
- **Ariana Barnes DnP, RN** — Implementing ICU liberation bundle with focus on delirium
- **Diana Tai MSN RN** — Escaping a code stroke: impact of escape room methodology on new hire nurses' attitudes towards acute stroke management guidelines

2. **Mentored nurses to formulate research questions, design study proposals, and conduct research. 2022 Research studies:**

- *Dietary, Sleep, and Exercise Habits of Registered Nurses (RN's) Working Full Time, 12-hour Day or Night Shift,* PI: Monica Malcuit MSN RN
- *Implementation of Childbirth Specific Patient Reported Outcomes Measures in the Hospital Setting (PICORI) Phase 2,* PI: Sue Jacobson

3. **Support of a nursing Providence Mission Hospital Nursing Research Council web page to communicate nursing research council meeting minutes, studies, projects and publications.**

4. **Research Council APNs Participated presented scholarly work for the Providence St. Joseph Nursing Research conference (August 12, 2022):**

- **MaryKay Bader** — "EBP approach to managing post-cardiac arrest"
- **Teresa Wavra** — "Improving fluid resuscitation in sepsis"
- **Jill Donaldson** — Conference moderator and conference planning committee member

Quality Council Accomplishments 2022

NURSE SENSITIVE INDICATORS

Magnet Requirement: Inpatient units must outperform on Nurse Sensitive Indicator benchmarks for falls with injury, hospital acquired pressure injuries stage 2 and above, CAUTI, and CLABSI, the majority of eight quarters. Also, three ambulatory nurse sensitive indicators will outperform the benchmark the majority of eight quarters.

UNIT LEVEL QUALITY ACTION TEAMS

1. NQC will sponsor and oversee performance improvement training utilizing the Quality Assurance Performance Improvement (QAPI) Starter kit and apply this training to at least one project per unit in 2022. Project can be related to patient experience, nurse sensitive indicator or a unit/department specific indicator that affects the strategic goals.
2. Fourteen Units have submitted QAPI plans, develop tactics and are beginning to report off accomplishments and project outcomes.

MEDICATION BAR CODE COMPLIANCE

1. Leapfrog Goal: increase or maintain medication bar code compliance scanning rates > 95%.
2. Currently meeting this goal in preparation for Leapfrog submission next year. Emergency room goal > 85%, did not meet this goal but improved from 2021

Leadership Council Accomplishments 2022

ANNUAL GOALS AND ACCOMPLISHMENTS

1. **Recruitment**

Goal: As a part of new hire orientation, nurses will be responsible for attending a Shared Governance meeting in their first year of hire. A goal of at least 60% of new hires should attend the meeting.

Target In Process: Due to Covid and staffing constraints most meetings were canceled in the beginning of the year. This goal was not attained and will be an area of focus for 2023.

Goal: Leadership council members to identify particular strengths and passion of new employees and recruit participation in Unit based Shared Governance meeting. Goal to increase participation by 25%.

Target In Process: Most units did not hold their unit-based meetings the first quarter of the year due to staffing and Covid. All units are currently holding SG meetings so although it is difficult to quantify specific percentage all units state participation has increased throughout the year but is not at pre-Covid numbers.

2. **Engagement/Retention**

Goal: Focus group of millennials to ascertain what makes work meaningful

Target Met: Due to Covid restrictions in person meetings were not held at the beginning of the year. Leadership reps individually questioned employees in their unit for ideas. In addition, evidenced based research was conducted and articles shared with team.

Goal: Create a platform for hybrid meetings where attendance via in person or remote is mandatory and participation encouraged by requiring video remain on throughout meeting.

Target In Process: All units have encouraged hybrid meetings and making available to increase attendance. Trauma and OB have increased attendance with hybrid model, other units limited increase in attendance due to hybrid meetings. Focus for 2023 to include adding goal for 50% in person attendance.

Goal: Create plan to increase manager/leadership engagement in meetings

Target in Process: The Leadership Committee has now acquired Kelly Ellis, APN as part of our committee. Jennifer Cord has also participated in the meeting as well. Units have encouraged their charge nurses and managers to attend.

Goal: Working in coordination with leadership team and Shared Governance councils roll out a Shared Governance Reboot meeting in 2022.

Target Met: Our Shared Governance reboot meeting was held on April 5, 2022. Over 100 people were in attendance and reviews were quite positive. Plans are underway to make this an annual event and tailor information to the audience.

3. **Awareness**

Increase nursing awareness of Shared Governance.

Goal: Leadership Council to create and host an information table during 2022 Nurses' week

Target Met: Although we did not have a traditional Nurses' week there was a luncheon during hospital week. We hosted an informational table and handed out flyers, small nursing gifts and answered questions.

Goal: Work in coordination with Education Council to include a Shared Governance informational brochure and survival items in a new hire welcome bag.

Target In Process: Informational brochure was created and utilized for above. Conversations are in process with the Education Council to complete the welcome bags.

4. **Information Dissemination** –

In an effort to improve accessibility to all Shared Governance Council activities, the NLC with the input from other councils will develop and implement two plans of action.

Goal: Unit Shared Governance Boards will be displayed prominently and updated in all units with 95% compliance by December 2022.

Target Met: All units currently have Shared Governance Boards on their units. Continued efforts and reinforcement will need to be done to ensure boards are kept up to date.

Goal: Participate in developing a means of accessing Housewide Shared Governance information electronically, which would be available to all staff.

Target In Process: The Education council has rolled out a comprehensive website that includes information about Shared Governance. Sarra Hem has been managing the website and we have had discussions regarding uploading agendas and minutes and encouraging more widespread use.

PULSE CHECK ACCOMPLISHMENTS

- Supply shortages in many units due to country wide supply chain issues. Recommendation to share par levels at Safety huddles to remediate problem and share supplies between units.
- Re-opening gym was delayed due to Covid precautions and room utilized for other services. Gym is viewed as a perk for staff. Gym reopened in fall.
- Laguna Beach – Need to hire transport team to assist in transporting from OR to floor. Not financially feasible, but PCT hired and recommendation that RN comes down from the floor to help transport if necessary. Resolved to their satisfaction
- Ascom Phones –Showing wrong date and time. System was rebooted and problem fixed.
- Laguna Beach having problems scheduling their fit tests. Expanded hours and better communication with staff fixed the problem.
- Neighboring hospitals paying $15 per hour for on-call pay. Escalated to Jennifer Cord and on-call pay increased to over $9/hr.
- RN's wanting to leave because cost of living too high and pay not commensurate. Ongoing concern but Jennifer escalating to management to do compensation review after Genesis issues fixed and get cost of living adjustments if needed.
- Uniform allowance discontinued. Concerns that it is mandatory to wear yet, no reimbursements. Jennifer checking with HR for guidance.

House Wide Education Council Accomplishments 2022

ANNUAL GOALS AND ACCOMPLISHMENTS

1. Patient Education Videos

House Wide Education Council (HWEC) exceeded the goal to increase the use of the Wellness Network Patient Education video library by 5%; in 2022 usage increased by 66%.

The content is made available to patients and families before, during and after their hospital stay using QR codes on the patient whiteboards and with bookmarks that have links with URL & QR code access on mobile devices. Specific patient populations have customized video lists that get assigned to them to view before admission or discharge.

2. Nursing Certification & Higher Nursing Education

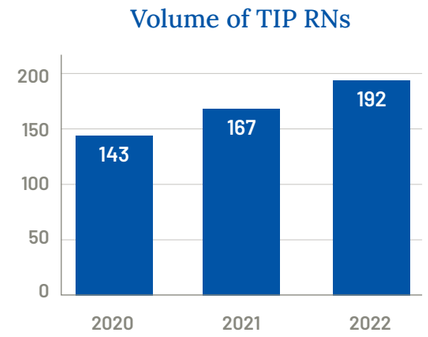
HWEC supports overall Nursing Professional Board Certification by providing certification information via the Providence Mission Hospital Education & Resource SharePoint, promoting use of Med ED review courses and System Library Resources that house certification review course materials. Information on affiliated schools and support for higher level of education is also on the Providence Mission Hospital Education & Resource SharePoint.

3. Nursing Education and Resource SharePoint Site

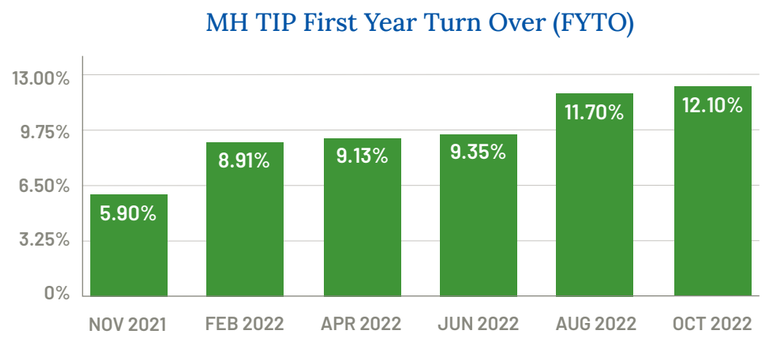
Providence Mission Hospital Education & Resource SharePoint site is a ONE-STOP SHOP for professional development, educational resources and classes/conferences, information on certification plus new this year access to house wide shared governance minutes and reference tools for clinical practice along with linking to regional/health system online platforms. Since the launch in August 2021, the site has had over 2,350 unique visits and over 9,800 total site visits. Site enhancements this year include icons for quick site navigation, and in the events and calendar section direct links to registration.

4. Transition in Practice Program

HWEC supports the Transition in Practice (TIP) Program by providing input to overall program design and implementation at Providence Mission Hospital. To help address our nurse staffing challenges, we have increased the volume of TI RNs:



Even with the increase in volume of TIP RNs, our TIP First Year Turn Over (FYTO) rate still remains one of the lowest in the region (under 15%) and well under the national average of 25%.



5. RQI Rollout

New in 2022, Providence Mission Hospital has moved to the Resuscitation Quality Improvement (RQI) Program by the American Heart Association, delivering quarterly training to support mastery of high-quality CPR skills. With RQI, healthcare providers have the confidence and competency to respond with life-saving patient care. The program includes cognitive component and skills assessment which are performed on any RQI station. Studies show that the conventional two-year AHA training cycle is not optimal for achieving the mastery learning of high-quality CPR skills needed to save more lives. CPR skills decay after 3-6 months. Consistent delivery of high-quality CPR positively impacts patient outcomes. Additional benefits include convenience, on work time, and improved patient outcomes.

6. Education Champion

Expanded role of HWEC Unit representatives to act as Education Champions who are supporting the bedside staff by ensuring open communication, act as superusers and collaborate with the Clinical Educators. Unit representatives ensure that the bedside staff are up to date on the monthly clinical practice alerts, in-services, HealthStream modules and other education initiatives from house wide shared governance councils and committees.

Pain Committee Accomplishments 2022

ACCOMPLISHMENTS

1. **Collect and report quarterly performance improvement data to all nursing units**
   - Patient satisfaction
   - Pain reassessment documentation (now a nurse-sensitive indicator)

2. **Achieved "Excellent Progress" in Cal Hospital Compare's Opioid Care Honor Roll in 2022**
   Achieved 'Excellent Progress' in taking necessary steps required by the program to ensure we offer appropriate opioid prescribing guidelines, OUD treatment, and overdose prevention strategies that reduces the use and risk of opioids for patients who visit emergency rooms, new patients with pain, and patients being discharged to reduce the likelihood of chronic use

3. Auditing provider opioid prescribing practices at time of discharge

4. Education via quarterly 1-minute "Pain Fast Facts"

5. Assisted with development of medication-assisted treatment program in the ER (Mission and Laguna Beach) in accordance to grant funding obtained by the California Bridge Program

6. Naloxone distribution project: established at Mission in collaboration with CDPH (enrolled in July 2022)
   - Created process for naloxone to be distributed to all high-risk in-patients, outpatients, friends and family
   - ER staff education
   - Mentoring BEAM nurse to take over naloxone distribution

7. Community outreach activities / overdose prevention at Aliso Viejo High School — April 2022

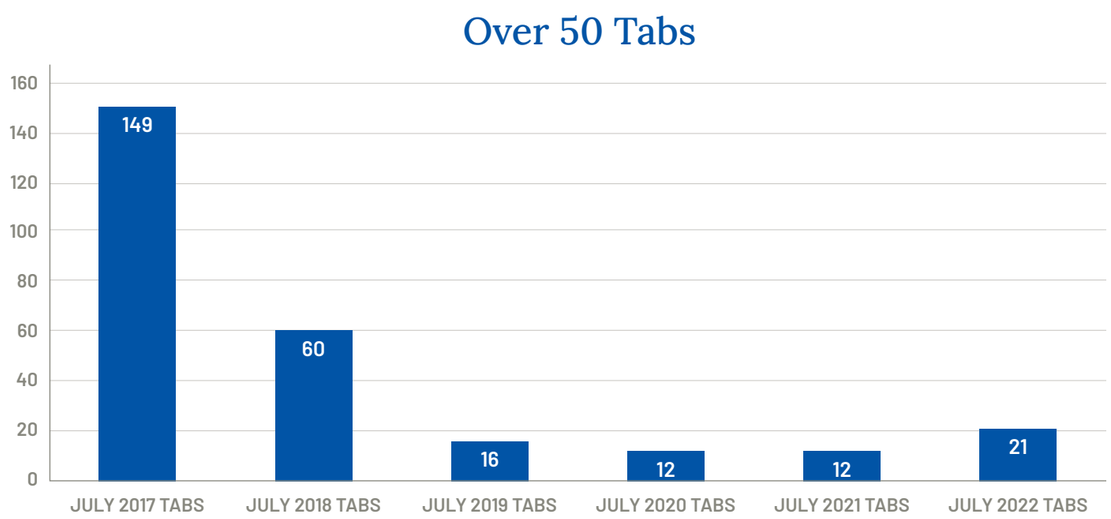
UNIT LEVEL QUALITY ACTION TEAMS

1. **Naloxone distribution project:** Created naloxone distribution policy and shared with all other participating Providence ministries.

2. Working with Marketing to create signage for ERs to inform patients that MAT is available at Providence Mission Hospital.

3. Developed evidence-based discharge prescribing guidelines across multiple service lines with goal of preventing new starts on long-term opioid treatment. Continuing to audit providers to ensure alignment with CDC and the American College of Surgeons recommendations for opioid prescribing. Outliers reported to CMO and medical staff.

   We have seen a steady decrease in the quantity of tabs prescribed at the time of discharge during the month of July from 2017 to 2021:



BEAM Accomplishments 2022

The Behavioral Evaluation and addiction management (BEAM) team is a group of nurses who are specialized in behavioral de-escalation and addiction management. This group of nurse's focus include the high-risk addiction, behavioral and CIWA patients with a focus on medication management to prevent code greys and workplace violence. The BEAM nurses proactively identify and manage patients who would benefit from a nurse trained in addiction management.

ANNUAL GOALS AND ACCOMPLISHMENTS

1. 257 Average encounters per month.
2. **Implemented Narcan Program** — Providence Mission Hospital participates in the Naloxone Distribution Project, and free naloxone can be provided to "at risk" patients and families by the BEAM nurses as well as all RNs working in the Emergency Department. Naloxone is stored in cupboards easily accessible to staff, as well as in the triage/admitting area for community members that come to Providence Mission Hospital seeking naloxone.
3. Decrease caregiver injury rate per 100 worked FTEs to from CY 21 0.88 to 0.16.
4. Added a Substance Use Navigator to complement the BEAM team to offer Medication assisted treatment is universally offered to all patients presenting with OUD, and BEAM nurses are called to the bedside to engage with patient to motivate them in seeking treatment.

Venous Thromboembolism (VTE) Performance Improvement Team

Providence Mission Hospital has consistently exceeded the National benchmark for PSI-12. The threshold for achieving a low VTE rate is very low (ie. Over 1 VTE per month will result in our rate exceeding the National benchmark

The original goals for the VTE PI team were based on VTE root case analysis. There were two primary gaps in care:

1. Prevent subtherapeutic anticoagulation by preventing unnecessary missed doses
2. Prevent VTE in hip fracture population by institution of new preop anticoagulation guidelines

AIMS AND OBJECTIVES

To reduce the incidence of VTE in hospitalized surgical patients (PSI-12). The goal was to attain a rate below the national benchmark of 3.85 in 2022. The Southern California region rate is 3.59.

GOALS

1. Address subtherapeutic anticoagulation
    - A. An EMR report was created to identify reasons why anticoagulants were being held. "Patient refusal" was very high, as well as doses held for platelet threshold.
    - B. In collaboration with pharmacy, the platelet threshold was changed from to 50 from 100.
    - C. RN education was provided with a focus on preventing unnecessary holds.
    - D. During chart review, specific instances where a dose was held by RN was followed up by contacting the nurse managers.
    - E. Two separate practice alerts were distributed cautioning RNs from holding anticoagulants, plus a mandatory Healthstream module.

2. Address anticoagulation in hip fracture patients with an extended ER to OR time without chemical prophylaxis

   A. Collaborated with Dr. Takeuchi, Dr. Wickham and orthopedic surgeons to develop a preoperative anticoagulation protocol. The protocol outlines how an anticoagulant order is initiated in the ER (written by PAs) if the ER to OR time is anticipated to be greater than 12 hours.

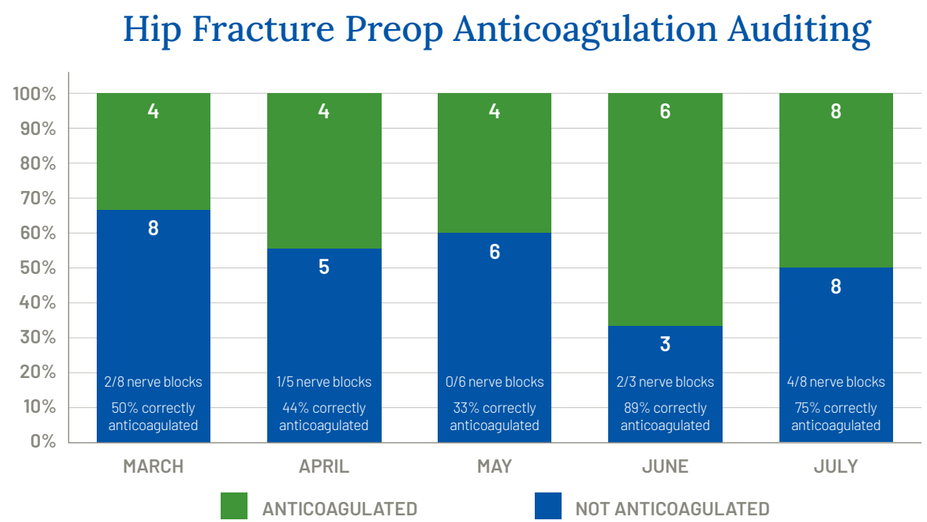
   B. Monthly audits are performed to determine compliance and data is reported to the VTE-PI team and orthopedic executive committee.

STUDY

1. We have only had 7 VTEs YTD in 2022, and only one was deemed to be potentially preventable by the team. There were no cases associated with missed anticoagulant doses. The PSI-12 rate at Providence Mission Hospital is now the lowest it has ever been (2.85) exceeding both the regional and national benchmark.

YEAR	CASES	SURGICAL VOLUME	RATE	BENCHMARK
2017	18	4070	4.42	3.86
2018	23	3829	6.01	3.85
2019	18	3057	5.89	3.85
2020	15	3553	4.22	3.76
2021	17	3276	5.19	3.76
2022	7	–	2.85 (YTD)	3.76

2. Since the preop hip fracture protocol was developed, we have not had any additional VTE in hip fracture patients since June 2021 (16 months), and we are currently 75% compliant to the hip fracture anticoagulation protocol.



ACCOMPLISHMENTS

1. Supporting new CNIII RN to ensure sequential compression device (SCD) compliance for patients transferred to and from surgery

2. Working on development of a PE Response team with the goal of becoming a leader in innovative VTE care and driving optimized care pathways from diagnosis to treatment resulting in a reduction in morbidity, mortality, and LOS.

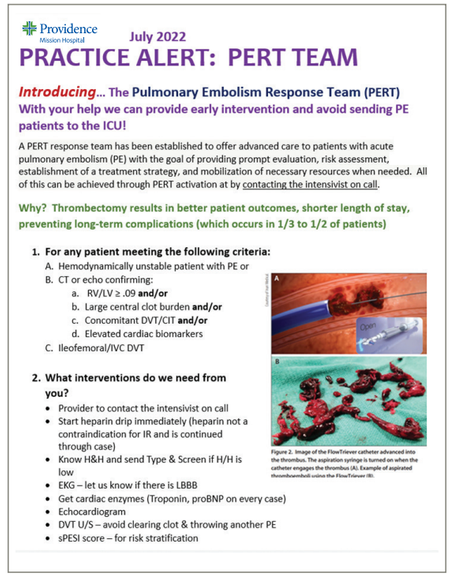
   A. Created new PE response team clinical guidelines (final approval 10/22).

   B. Created practice alert.

   C. Working with Swedish to Beta test new EPIC MD orders.

   D. RN education in ER November 1-2, 2022), plan to expand to additional nursing units prior to the end of the year.

   E. Need to develop reliable EMR report to ID VTE cases and standardized patient follow up process.



Providence Mission Hospital

July 2022

PRACTICE ALERT: PERT TEAM

***Introducing*... The Pulmonary Embolism Response Team (PERT)**
With your help we can provide early intervention and avoid sending PE patients to the ICU!

A PERT response team has been established to offer advanced care to patients with acute pulmonary embolism (PE) with the goal of providing prompt evaluation, risk assessment, establishment of a treatment strategy, and mobilization of necessary resources when needed. All of this can be achieved through PERT activation at by contacting the intensivist on call.

Why? Thrombectomy results in better patient outcomes, shorter length of stay, preventing long-term complications (which occurs in 1/3 to 1/2 of patients)

1. **For any patient meeting the following criteria:**
   A. Hemodynamically unstable patient with PE or
   B. CT or echo confirming:
      a. RV/LV ≥ .09 **and/or**
      b. Large central clot burden **and/or**
      c. Concomitant DVT/CIT **and/or**
      d. Elevated cardiac biomarkers
   C. Ileofemoral/IVC DVT

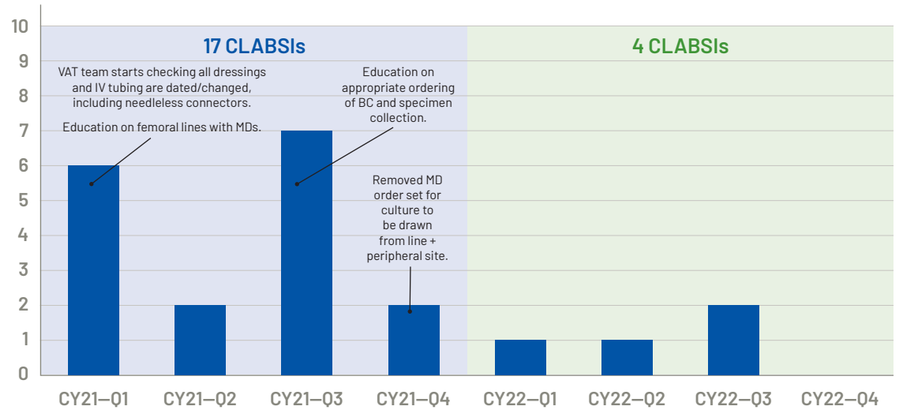
2. **What interventions do we need from you?**
   - Provider to contact the intensivist on call
   - Start heparin drip immediately (heparin not a contraindication for IR and is continued through case)
   - Know H&H and send Type & Screen if H/H is low
   - EKG – let us know if there is LBBB
   - Get cardiac enzymes (Troponin, proBNP on every case)
   - Echocardiogram
   - DVT U/S – avoid clearing clot & throwing another PE
   - sPESI score – for risk stratification

Figure 2. Image of the FlowTriever catheter advanced into the thrombus. The aspiration syringe is turned on when the catheter engages the thrombus (A). Example of aspirated thromboembolic using the FlowTriever (B).

Hospital-Acquired Infections

The number of CLABSIs at Providence Mission Hospital during CY2021 was 17, which is 14 over target. Ongoing work during 2022 included CLABSI prevention bundle compliance (routine dressing changes performed by the VAT team), continuing to ensure appropriate device selection, measures to prevent blood culture contamination, and preventing line/luer contamination.

Central Line-Associated Bloodstream Infections
Mission Viejo

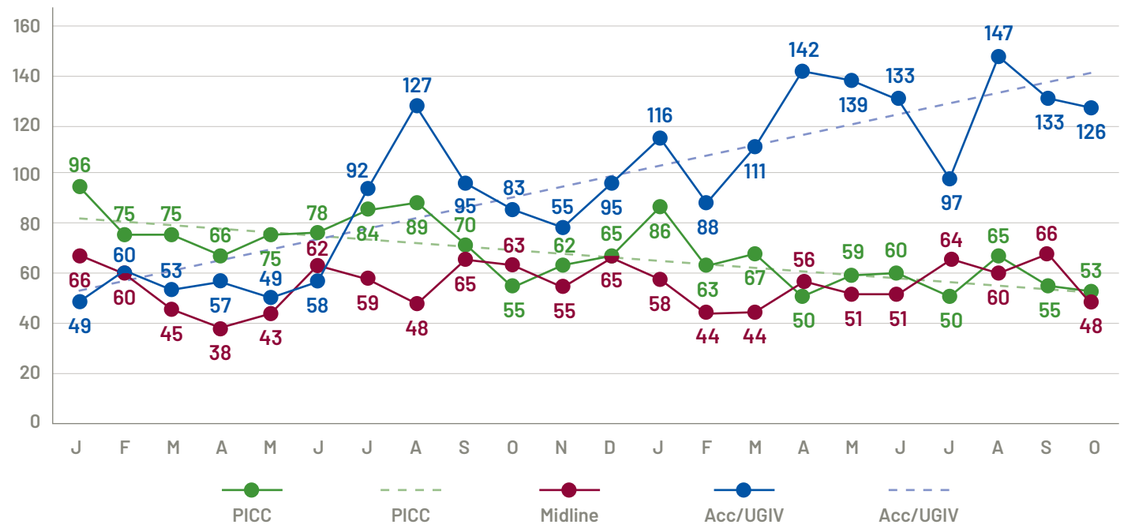


In 2020, only 50% of PICCs met criteria for central line. A new evidence-based invasive line selection guideline was created. RNs and MDs were educated, and the VAT team helped by ensuring line appropriateness according to our policy:

This practice change was sustained by having the VAT team audit all lines placed over nine months and reporting unnecessary or inappropriately placed lines back to CLABSI PI team

Following this intervention, our PICC line insertions have been reduced by 30% since 2020, and ultrasound-guided IV placements have increased by 103%.

Monthly Volume: Cascular Access Devices Placed by VAT



AIMS AND OBJECTIVES

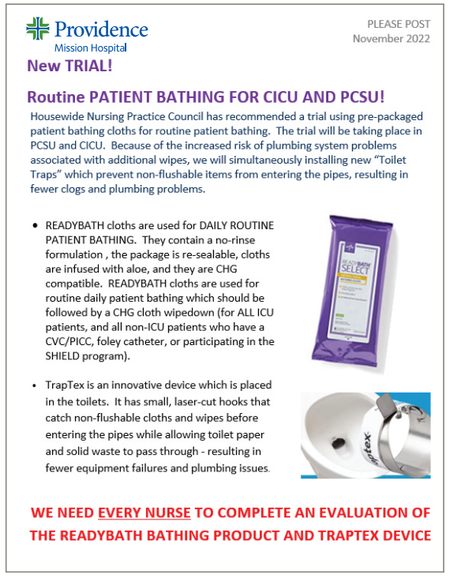
1. Reduce risk of central line-associated bloodstream infections, promote optimal vascular access practices, and promote culture of safety surrounding central line insertion, maintenance, and removal.
2. In 2021, our goal was to "Reduce CLABSI SIR for Providence Mission Hospital by 50% and to achieve 3 CLABSIs or fewer in 2022."

ACCOMPLISHMENTS

1. VAT team provides concurrent reporting of variances in best practices to PI team and collaborating with staff to ensure line appropriateness policy is met, thereby preventing unnecessary line placements
2. Created competency and additional RN education on using proper aseptic procedures while obtaining blood cultures. Standardized line dressings to 3M CHG impregnated dressings, eliminating CHG patch from the hospital (including standardizing central line kits in the ICU)
3. Changed policy so that blood cultures are not drawn from a line. EPIC EMR MD orders changed to reflect cultures drawn peripherally.
4. Changed practice so that all lines (except peripheral) are dressed with a 3M CHG dressing (arterial lines, midlines, etc.) and collaborating with all disciplines to ensure compliance
5. Introduced new product called stat seal to prevent weeping dressings and prevent unnecessary dressing changes
6. Created standard work for appropriate blood culture specimen collection preventing unnecessary collection of specimens
7. Introduced new "red cap" disinfecting product to prevent contamination of luers and stockcocks
8. Created standard for VAT team to perform routine replacement of all CVC/PICC/A-line, and non-routine dressing changes require two RNs to perform.

IN PROGRESS

1. Continued work on standardization of routine patient bathing including introduction and trial of new disposable bathing product and collaborating with Facilities to trial TrapTex device to prevent plumbing issues
2. Changing routine IV tubing replacement from Q96 hours to Q7 days
3. Supporting new CNIII project by ER RN to address blood culture contamination thereby reducing false-positive, contaminated specimens



Providence Mission Hospital

PLEASE POST
November 2022

New TRIAL!

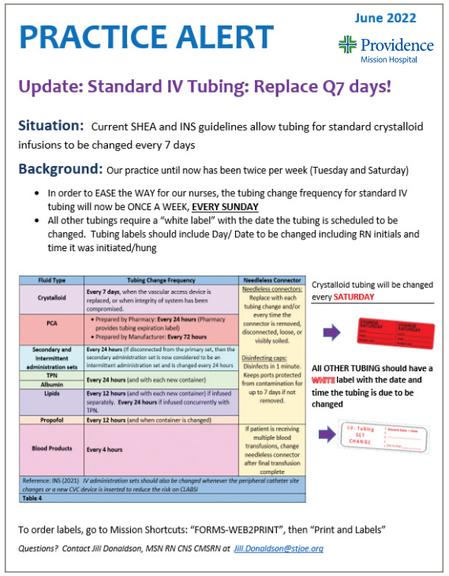
Routine PATIENT BATHING FOR CICU AND PCSU!

Housewide Nursing Practice Council has recommended a trial using pre-packaged patient bathing cloths for routine patient bathing. The trial will be taking place in PCSU and CICU. Because of the increased risk of plumbing system problems associated with additional wipes, we will simultaneously installing new "Toilet Traps" which prevent non-flushable items from entering the pipes, resulting in fewer clogs and plumbing problems.

- READYBATH cloths are used for DAILY ROUTINE PATIENT BATHING. They contain a no-rinse formulation , the package is re-sealable, cloths are infused with aloe, and they are CHG compatible. READYBATH cloths are used for routine daily patient bathing which should be followed by a CHG cloth wipedown (for ALL ICU patients, and all non-ICU patients who have a CVC/PICC, foley catheter, or participating in the SHIELD program).

- TrapTex is an innovative device which is placed in the toilets. It has small, laser-cut hooks that catch non-flushable cloths and wipes before entering the pipes while allowing toilet paper and solid waste to pass through - resulting in fewer equipment failures and plumbing issues.

WE NEED EVERY NURSE TO COMPLETE AN EVALUATION OF THE READYBATH BATHING PRODUCT AND TRAPTEX DEVICE



PRACTICE ALERT

June 2022

Providence Mission Hospital

Update: Standard IV Tubing: Replace Q7 days!

Situation: Current SHEA and INS guidelines allow tubing for standard crystalloid infusions to be changed every 7 days

Background: Our practice until now has been twice per week (Tuesday and Saturday)

- In order to EASE the WAY for our nurses, the tubing change frequency for standard IV tubing will now be ONCE A WEEK, **EVERY SUNDAY**
- All other tubings require a "white label" with the date the tubing is scheduled to be changed. Tubing labels should include Day/ Date to be changed including RN initials and time it was initiated/hung

Fluid Type	Tubing Change Frequency	Needleless Connector
Crystalloid	**Every 7 days**, when the vascular access device is replaced, or when integrity of system has been compromised.	Needleless connectors: Replace with each tubing change and/or every time the connector is removed, disconnected, loose, or visibly soiled.
PCA	• Prepared by Pharmacy: **Every 24 hours** (Pharmacy provides tubing expiration label) • Prepared by Manufacturer: **Every 72 hours**	
Secondary and Intermittent administration sets	**Every 24 hours** (if disconnected from the primary set, then the secondary administration set is now considered to be an intermittent administration set and is changed every 24 hours	Disinfecting caps: Disinfects in 1 minute. Keeps ports protected from contamination for up to 7 days if not removed.
TPN	**Every 24 hours** (and with each new container)	
Albumin		
Lipids	**Every 12 hours** (and with each new container) if infused separately. **Every 24 hours** if infused concurrently with TPN.	
Propofol	**Every 12 hours** (and when container is changed)	
Blood Products	**Every 4 hours**	If patient is receiving multiple blood transfusions, change needleless connector after final transfusion complete

Reference: INS (2021) *IV administration sets should also be changed whenever the peripheral catheter site changes or a new CVC device is inserted to reduce the risk on CLABSI*
Table 4

Crystalloid tubing will be changed every **SATURDAY**

All OTHER TUBING should have a WHITE label with the date and time the tubing is due to be changed

To order labels, go to Mission Shortcuts: "FORMS-WEB2PRINT", then "Print and Labels"

Questions? Contact Jill Donaldson, MSN RN CNS CMSRN at Jill.Donaldson@stjoe.org

PRACTICE ALERT

Providence Mission Hospital

NEW CUROS STOPPER CAPS COMING SOON!

Curos™ Stopper Disinfecting Cap for Open Female Luers

1. Use 3M Curos Stopper Disinfecting Caps to disinfect and protect open female luers, stopcocks, and arterial lines
2. Do NOT USE on 1. needleless connectors, 2. catheter hubs or 3. neuro drains

Providence Mission Hospital

Standard Work	**Blood Cultures**
Audience	MD/RN/IP/Laboratory
Objective	Provide a standardized, evidence-based method of Blood Culture collection that minimizes contamination risk and optimizes detection of true bacteremia when present
Description/Definition	**Ensure use of standards to improve patient selection and decrease potential specimen contamination** 1. *Patient selection:* Blood cultures should only be performed in patients felt to have a reasonable likelihood of bacteremia/fungemia and in whom the culture result would *meaningfully* impact future therapy decisions. 2. *Phlebotomy use:* Do not obtain blood cultures from Vascular Access devices (VADs) when suspecting a central line infection. They are more likely to produce false-positive results. Use of a VAD for this purpose should be limited to situations involving difficult venous access when use of vascular visualization has failed. 3. *Specimen collection:* If blood culture collection via a vascular catheter must be used, ensure proper collection procedure is followed to minimize the risk of contamination

Steps	Instructions	Who
Initial Order	1. Once a blood culture is ordered, the primary nurse will notify the charge nurse promptly and discuss/evaluate necessity for blood culture based on grid below: 2. If a patient is "Very Low" or "Low" risk, the ordering physician will be contacted by the primary nurse and made aware of the predicted low yield in these scenarios. If the physician still wishes to obtain blood cultures, they will be obtained without delay. The Nurse Manager will then be notified of this occurrence and forward the pertinent information to Infection Prevention. 3. Infection Prevention will review these reports retrospectively. When appropriate, the Medical Director of Infection Prevention will discuss the diagnostic stewardship issues raised with the ordering physician.	MD/RN/ Charge Nurse/ Infection Prevention

Very Low (< 3%)	Low (< 10%)	Low-moderate (10 to < 20%)	Moderate (20 to < 50%)	High (≥ 50 %)
• Fever within 48h of a surgical procedure • Isolated, non-repeated or sustained fever	• Uncomplicated cellulitis • Lower tract UTI • CAP/HCAP	• Cellulitis in patients with severe comorbid conditions or severe episode of cellulitis • VAP	• Acute Pyelonephritis • Cholangitis • Pyogenic liver abscess • Severe CAP • Non-vascular shunt infections • Severe sepsis • Fever with rigors	• Discitis, vertebral osteo • Epidural abscess • Acute septic joints • Meningitis • Ventriculo-atrial shunt infections • Septic shock • Catheter-related BSIs
Blood cultures (BC) not warranted (Potential for false-positive result > valid true positive)		**BC may be warranted** if unable to culture primary site prior to abx treatment	**BC warranted**, especially if unable to culture primary site prior to abx	**BC routinely warranted**

BEST PRACTICE ALERT

April 2022

Providence Mission Hospital

Blood Sampling from a Vascular Device

Vascular access devices should be used for drawing blood only when necessary, and the risk of infection must be weighed by the benefit to the patient (INS, 2021).

1. If a specimen is obtained through a vascular device, this is how to do it:
   A. Obtain supplies:
      - 2- 10mL prefilled NS syringes
      - Antiseptic pads (CHG-based alcohol, or curos cap)
      - (2) Blood culture bottles: aerobic and anerobic
      - Blood transfer device
      - Gloves

   B. Stop all infusions, including those running through another lumen of the CVC
   C. Do NOT remove the needleless connector. The Specimen should be obtained thro
   connector.
   D. Clamp the CVC lumen or if sampling from an A-line, turn the stopcock off to the flu
   E. If necessary, detach the administration set from the needleless connector and pla
   end of the administration set to *prevent contamination*
   F. If no IV fluids are infusing and a disinfecting cap is covering the end of the needle
   and discard it
   G. Hub disinfection:
      a. Needleless connector on CVC: Remove disinfecting end cap, OR perform a
      scrub of the needleless connector for 10-15 seconds using an antiseptic pa
      b. Arterial line: Perform a vigorous mechanical scrub of the blood sampling port for
      an antiseptic pad. Allow it to dry completely
   H. Specimen collection:
      a. Needless connector on CVC: While maintaining sterility of the syringe tip, a
      mL syringe to the needleless connector or port. Unclamp the catheter and
      blood, then push to reinfused the blood into the catheter. Use the attache
      flushing to aspirate the appropriate blood sample. **Change the needleless**
      blood is not completely flushed and removed. Resume any interrupted infu
      the device using a push-pause technique (*short boluses of flush solution int
      may be more effective at removing deposits).* Place alcohol-containing end
      connector *to reduce the risk of CLABSI*
      b. Arterial line: Connect the luer-lock end of the syringe to the blood sampling
      turn off the stopcock to flush the solution. Obtain a discard sample by with
      blood needed to clear the catheter of flush solution. Activate the fast-flush
      tubing
   I. **Label**: Clearly label each specimen set with source/site and draw time/date

Questions? Contact Jill.donaldson@stjoe.org or Carolyn.khong@

VASCULAR ACCESS DEVICE SELECTION

Providence Mission Hospital

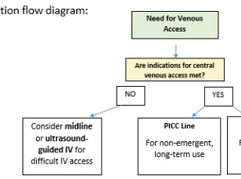
YOU can help to PREVENT CLABSI by ensuring patients receive appropriate vascular access devices based on medical need.

AS A TEAM we can do this by:

1. Ensuring **PICC lines** are used only for **non-emergent, LONG TERM use only (≥ 6 days)**
2. MDs placing **CENTRAL LINES** for **emergent, SHORT TERM use only (> 5 days)**

WHY? CDC, MAGIC, and INS CLABSI guidelines recommend against the use of PICCs when the expected duration of use is 6 days or less.[1] PICC lines are associated with a and upper extremity DVT.

WHAT HAS CHANGED? We have a new evidence-based venous selection flow diagram:



IF we need a PICC, should we default to a Triple Lumen? NO. Avo (5Fr) PICCs. Consider single or double-lumen (4Fr) first.

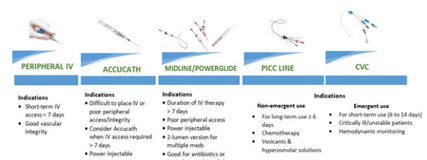
Why? Several studies have linked the number of PICC lumens with major co and CLABSI[2,3,4]. Studies that have minimized lumens have reduced CLABSI a guidelines recommend using the minimal number of device lumens to meet example of an indication for a triple-lumen PICC would be a concurrent adm vasopressor, and hemodynamic monitoring.

How do we know if a Central Line/PICC meets medical necessity? Indications for central venous access are located in our IV Care & Maintenance Guideline:

NOTE: Antibiotics and IV access are NOT indications for a PICC line

- ☐ TPN (> 900 mOsm/L)
- ☐ Chemotherapy / vesicants
- ☐ Vasopressors/inotropes (Dopamine, Dobutamine Epi, norepi, phenylephrine, vasopressin) with planned infusion time > 24 hours (Peripheral administration into large vein may be used with routine site assessment until a PICC/CL is established)
- ☐ Amiodarone (concentration < 2 mg/mL) if required > 3 days. Central line required for amiodarone concentrations that exceed 2 mg/mL
- ☐ One of the following Vesicants or hyperosmolar solutions (IV infusions, NOT IV push)
  - Arginine
  - Dextrose 12.5% or higher concentration
  - Mannitol 20% or higher concentration
  - Hypertonic sodium chloride concentration higher than 3%
  - Calcium chloride ≥ 3%
  - Sodium bicarbonate
- ☐ Pulmonary hypertension meds (Flolan, Remodulin) note: a PIV may be used until PICC/CVC established
- ☐ Invasive hemodynamic monitoring
- ☐ Frequent phlebotomy (every 8 hours) for duration of ≥ 6 days
- ☐ Patient being discharge home on long term antibiotics when proposed duration > 2 weeks
- ☐ Miscellaneous medications: KCL > 10mEq/100mL, Conivaptan (Vaprisol), Hemin (Panhematin)
- ☐ Incompatible medications that must be given simultaneously (list):

Always select the appropriate vascular device based on patient need, and remove as soon as it is no longer clinically indicated:



Restraint Committee

To improve regulatory compliance for restraint orders, monitoring documentation, and care plans, additional clinical engagement was necessary to accomplish these goals. Metric goals are identified through auditing and improvement processes continued through 2022.

AIMS AND OBJECTIVES

Restraints present a high safety risk for patients and therefore are a focus of all regulatory agencies during the survey process. The aim of the 2022 Restraint Committee was to meet targeted goals of the committee by increasing physician and nursing engagement, creating standardized education, and improving regulatory compliance for restraint orders and documentation.

GOALS

Four metric goals identified through the 2022 auditing process:

1. Physician face-to-face violent restraint documentation within one hour of application
2. Restraints included in plan of care
3. Restraint monitoring documentation by RN
4. Restraint type applied matches the order

The plan for 2022 included the following steps to improve the four identified metrics:

1. Recruit representatives for nursing units utilizing restraints that were no longer represented.
2. Provide restraint education for Physician and Nurse Restraint Committee members.
3. Create and disburse EPIC educational restraint reference tools to all nursing units that utilize restraints.
4. Continue to stay informed of new CMS (Centers for Medicare Services) and Joint Commission Guidelines and make policy changes as needed.

ACCOMPLISHMENTS

Recruitment Efforts and Results:

1. **February 2022** — Four Nurse Managers emailed to identify a new RN representative to join the Committee.
2. **March–September 2022** — Seven new RNs and one new Physician joined the Restraint Committee.
3. **April, 2022** — Jill Donaldson assumed the role of Restraint Committee Advisor.

Targeted physician and nursing restraint member education, educational tools and auditing techniques:

1. Restraint Committee Charter created and approved in March of 2022.
2. Clinical Practice Alert distributed March 7, 2022 on Implicit bias related to restraint use.
3. Due to supply issues in June, all NM were warned of vests without required quick release buckles on units.
4. Supply Chain Manager removed vests without the quick release buckle, proper vests stocked in three days.
5. Expert recommendations made during the creation of the Providence Healthstream restraint education.
6. The Committee signed off on a new orientation restraint checklist developed by the Education Department.
7. Virtual restraint education provided for all RNs through HealthStream in September 2022.
8. Epic Restraint Quick Reference tool sent to all nursing units to be displayed in the respective units.
9. September, 2022, EPIC Tableau data review initiated to audit 100% of restraints from both campuses.
10. Monthly manual representative audits will continue to identify optimized charts for best practice.
11. Monthly graphs and charts presented by Kristen Adams to document restraint metric goal progress.

Restraint Policy Changes to incorporate new CMS and Joint Commission Guidelines:

1. Reviewed CA-So Cal Region Providence hospital policy. Provided feedback to authors. Awaiting response to inquiry about using manual restraints.

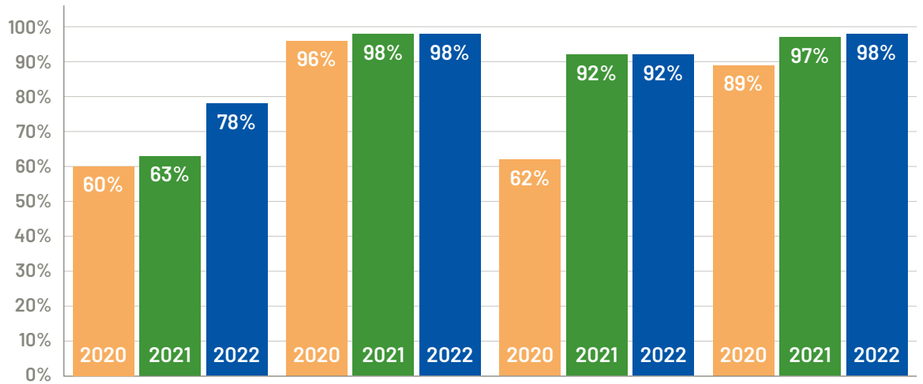
STUDY

1. The Physician violent restraint one-hour face-to-face documentation compliance climbed from 63% in 2021, to 78% by the end of 2022.
2. EPIC has aids that provide prompts for order entry and signals providers when violent restraint one-hour face-to-face documentation is required.
3. The metrics of Monitored by RN, and Included in Care Plan remained steady at 92% and 98% respectively.
4. The last metric, Type Matches Order increased 1% from 2021 to 2022.
5. Restraint education is provided virtually to all RNs annually through HealthStream.

6. Restraint Committee members performed monthly restraint audits, and reported results utilizing a Microsoft forms tool throughout 2022. In addition, daily Nurse Manager/Charge Nurse led restraint audits were completed every shift, allowing nurses to make corrections to restraint documentation in real time.

7. Restraint audit data and problem areas were discussed at the bi-monthly Restraint Committee meetings. Throughout 2022, questions sent to the Restraint Committee were answered by e-mail, often quoting the latest CMS Survey Protocol, Regulation and Interpretive Guidelines for Hospitals or the Mission Restraint policy.

Restraint Committee Year-Over-Year Audits



MOVING FORWARD

1. Reach out to Nurse Managers for units that no longer have a representative.
2. Plan to distribute MD education in January 2023 via medical staff office.
3. Targeted education for nursing units with greatest opportunity to improve restraint documentation.
4. Adopt the Providence CA-So Cal Region Restraint policy.
5. Educate M.D.s and RNs concerning changes once the policy is in effect.

ICU Liberation Initiative

The multidisciplinary team members involved in caring for critically ill patients include critical care physicians and nurses and providers from Rehabilitation, Respiratory Therapy, Nutritional Care, and Pharmacy. Members from the various services met originally in 2013–2014 and created an evidence based protocol called the ABCDE protocol. Society of Critical Care Medicine (SCCM) launched the ICU Liberation Initiative a few years ago to encourage critical care teams to implement the ABCDEFG bundle of care to improve outcomes in critically ill patients. Studies have found that implementing the ICU liberation bundle decreases mortality 15% as well as ICU length of stay and improves the physical and psychological outcomes of ICU patients. In 2022, the same team from 2013–2014 reevaluated the literature and revised the ABCDE protocol and renamed the ICU Liberation ABCDEFG protocol. Meeting on a quarterly basis the team is led by Mary Kay Bader RN, MNS, CCNS — Neuro/Critical Care Clinical Nurse Specialist (CNS); Tauseef Qureshi, MD — Medical Director of Critical Care; Marne Andersen, RN, MSN — Nurse Manager Critical Care; Teresa Wavra, RN, DNP, CNS — Cardiovascular CNS; and Jennifer Cord, RN, DNP — Chief Nursing Officer. Nurses from SICU/CICU, Critical Care Physicians/Nurse Practitioner, Therapists — PT/OT and Respiratory Care Practitioners, Pharmacist, and Dietitian meet to determine the best strategies to achieve compliance with the ABCDEFG bundle of care.

In 2022, improving compliance to the bundles was achieved with the following strategies:

1. Standardized timing in both ICUs for the Spontaneous Awakening Trial (SAT)and Spontaneous Breathing Trial (SBT).
2. Created colored crosses (green cross = do the SAT/SBT and red cross = do not do SAT/SBT) which are placed on the ventilator to inform team members of the status.
3. CNSs from CICU/SIC conduct daily rounds at 730-830am surveying the presence of the crosses on the ventilators.
4. Created a revised multidisciplinary rounds (MDR) format ABCDEFGHI to match the priorities in the ICU liberation initiative.
5. Created an Epic MDR Patient shared list which pulls data on each of the elements (ABCDEFGHI) allowing the bedside nurse to have the information readily available for MDRs.
6. Created an educational video and posttest for all staff highlighting the important elements of the ABDEDFG protocol.
7. Established a competency for nurses, respiratory therapists, PT/OT, Pharmacy using the Donna Wright Competency Model.
8. Conducted the education with 100% compliance with the education in Health Stream.
9. Asked the informatics experts for access to the My Highway report on compliance to the ICU liberation.

10. Gather compliance information on a monthly basis and report it to Critical Care Committee examining areas of improvement.

11. Encourage early mobility strategies with all staff.

Mission Hospital's data is the best in the Providence Health System Southern Division. The team continues to monitor compliance and institute creative ways to improve our implementation of the ICU liberation initiative.

ICU LIBERATION ROUNDS

A	Assess and Manage Pain Level?
B	Was it safe to stop sedation today? SAT P/F Was it safe to change to CPAP/PS mode? SBT P/F
C	GI: Famotidine or Pantoprazole DVT: SCDs / Pharmacologic (Heparin or Enoxaparin)
D	Delirium: Is the CAM-ICU positive?
E	Ergometry__ OOB__ Walking__ PT__OT __ What are the rehabilitation goals for today?
F	Are there family needs that we can help meet?
G	Goals of Care: Code Status: DC options:
H	Cumulative I&O: Nutrition: Route_____ Goal_____ Last BM:_____ Bowel Regimen?_____
I	CVC/PICC Location and Indication: _____ Plan for removal? A Line Location and Indication: _____ Plan for removal? FC Day and Indication: _____ Plan for removal? Antibiotic Regimen- Indication: _____

The purpose of interprofessional ICU rounding is to engage in a collaborative practice to ensure high-quality outcomes and minimize risk to our patients. This is an example of the ABCDEFGHI MDR format set up by the ICU Liberation Committee.

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision

Health for a Better World

Our Values

COMPASSION

Jesus taught and healed with compassion for all.

— Matthew 4:24

DIGNITY

All people have been created in the image of God.

— Genesis 1:27

JUSTICE

Act with justice, love with kindness and walk humbly with your God.

— Micah 6:8

EXCELLENCE

Whatever you do, work at it with all your heart.

— Colossians 3:23

INTEGRITY

Let us love not merely with words or speech but with actions in truth.

— 1 John 3:18"

Our Promise

"Know me, care for me, ease my way."

Our Nursing Vision

To be recognized as a leader in providing patient and family-centered nursing care by supporting a professional, values-based culture that demonstrates clinical excellence, fosters respect and delivers holistic care in a fiscally-responsible environment.

Providence
Mission Hospital

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