Visibility, Accessibility, and Communication TL9EO

Choose two of the following:

a. Provide one example, with supporting evidence, of an improvement in patient care or the nursing practice environment associated with communication between the clinical nurse(s) and the CNO.
   ➢ Outcome data must be submitted in the form of a graph with a data table.

b. Provide one example, with supporting evidence, of an improvement in patient care or the nursing practice environment associated with communication between the clinical nurse(s) and an AVP/nurse director.
   ➢ Outcome data must be submitted in the form of a graph with a data table.

c. Provide one example, with supporting evidence, of an improvement in patient care or the nursing practice environment associated with communication between the clinical nurse(s) and a nurse manager
   ➢ Outcome data must be submitted in the form of a graph with a data table.

Example a: Improvement in Patient Care Resulting from Communication Between Clinical Nurse and the CNO

Problem
In February 2018, Clinical Nurse Hayes McCaffrey, BSN, RN, CCRN-P, Pediatric Intensive Care Unit (PICU), noted an increase in the number of unsuitable specimen notifications the PICU was receiving from the laboratory. These unsuitable specimens (hemolyzed, clotted or insufficient specimen quantity) were resulting in pediatric patients having to undergo another peripheral intravenous stick to get a specimen. The percentage of unsuitable specimens requiring a restick to draw specimens in February 2018 was 6.70%. This is calculated by dividing the number of unsuitable pediatric patients requiring a restick to draw specimens by the total number of pediatric lab draws for the month, multiplied by 100.

Goal Statement
The goal was to decrease the percentage of PICU patients requiring a restick to draw specimens.

Participants

<table>
<thead>
<tr>
<th>Name/Credentials</th>
<th>Discipline</th>
<th>Title/Role</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hayes McCaffrey, BSN, RN, CCRN-P</td>
<td>Nursing</td>
<td>Clinical Nurse</td>
<td>PICU</td>
</tr>
<tr>
<td>Cindy Boily, MSN, RN, NEA-BC</td>
<td>Nursing</td>
<td>Sr. VP &amp; CNO</td>
<td>Administration</td>
</tr>
<tr>
<td>Chantal Howard, MSN, RN, CEN, NEA-BC</td>
<td>Nursing</td>
<td>VP Nursing Raleigh Campus</td>
<td>Nursing Administration</td>
</tr>
</tbody>
</table>
Description of the Interventions

**March 2018**

- McCaffrey brought to the PICU Unit Council the issue of the increase in unsuitable specimens to determine whether other nurses were also experiencing this issue and to discuss opportunities for improvement. The increase in unsuitable specimens meant that pediatric patients had to undergo another peripheral stick to get a viable specimen after the initial specimen was determined to be of insufficient quantity, hemolyzed or clotted. McCaffrey was encouraged to bring this issue to the chief nursing officer at the Clinical Nurse Council (CNC) meeting.

**April 2018**

- The CNC meeting is a forum in which clinical nurses can voice concerns, provide updates and bring new information to each other and the CNO.
- During every CNC meeting, approximately 65 CNC representatives have the opportunity to ask questions and get answers directly from Cindy Boily, MSN, RN, NEA-BC, Chief Nursing Officer and Senior Vice President.
- Questions related to nursing professional development, nursing practice environments, patient care, communication and organizational issues are discussed during this intentionally designed time.
- During this CNO open forum, McCaffrey raised the issues of missing patient laboratory samples, delayed laboratory results and redraws from pediatric patients due to insufficient quantity.
- Immediately upon hearing these concerns, Boily responded to the CNC group and charged Chantal Howard, MSN, RN, CEN, Vice President of Nursing Raleigh Campus, to create a Nursing and Laboratory Collaborative Task Force to further investigate the issues.
- Boily asked the CNC representatives whether anyone else had similar issues and wanted to participate on the task force.
- McCaffrey and CNC representatives from the Children’s Emergency Department volunteered to participate.
- There are only a select few units within WakeMed that have nurse drawn labs: all Emergency Departments, Pediatric Units, Neuro ICU and step down units, Labor and Delivery, PACU and all other adult ICUs.

**May 2018**

- Howard facilitated the first meeting of Nursing and Lab Collaborative Task Force.
- The task force identified the following issues:
Pediatric micro tubes have less specimen yield for tests.
Additional tests cannot be conducted when using the smaller blood specimen micro tubes.
The use of the micro tubes requires a manual process in the lab that delays results and results in an additional financial cost.
Improper technique can also result in hemolysis of samples, requiring redraws.

- Terri Menzel, Supervisor Pathology, stated that the foam in the pneumatic tubes protects the specimen from excessive shaking to prevent hemolysis. McCaffrey and Clinical Nurse Christina Guzman, BSN, RN, CPEN, Children’s Emergency Department (CED), noted they had sent specimens in tubes without the foam.
- The Unsuitable Specimen Report was sent to all managers, supervisors and CNC representatives across the system.
- Management was encouraged to follow up with clinical nurses who had a high percentage of hemolysis errors to identify opportunities for re-education.
- Laboratory placed foam inserts in pneumatic tubes to help prevent hemolysis. 80% of the pneumatic tubes were missing foam.
- The Follow A Specimen Today (FAST) program was developed to give nurses an opportunity to follow a laboratory specimen from collection to result, tour the laboratory and ask questions of the collection, processing and technical staff. The nurses who participated were then asked to take key learning points from the program back to their peers.

**June 2018**
- The first nursing group, including the following, completed the FAST program tour of the laboratory: Lisa Miller, BSN, RN, CPEN, Clinical Supervisor/Educator CED; Lindsay Robinson, BSN, RN, CPEN, Clinical Supervisor/Educator CED; Sarah Hassing, BSN, RN, CPEN, Clinical Educator/Supervisor CED; Trisha Jones, BSN, RN, CPN, Clinical Educator/Supervisor 4E Pediatrics; Cameron Sanders, BSN, RN, CPN, Clinical Educator/Supervisor 4E Pediatrics; and Wanda Bowman, BSN, RN, NE-BC, Nurse Manager 4E Pediatrics PICU.
- The FAST program was also completed by Guzman; Cassie Knittel, Nursing Aide I, CED; Katie Lee, RN, Clinical Nurse 5B Neuro Intermediate Care; Matthew Shaw, RN, Clinical Nurse 5B Neuro Intermediate Care; Yvonna Rodriguez, RN, Clinical Nurse 5B Neuro Intermediate Care; and Katie Whitacre, RN, 5B Neuro Intermediate Care.
- FAST dates for Pediatric and PICU clinical nurses to observe a specimen for two hours were available through June.
- McCaffrey and Guzman presented the information that was uncovered during the laboratory task force meeting to the system-wide CNC representatives at the June 7, 2018 meeting.
- Flyers addressing frequently asked questions related to preventing hemolysis of blood samples and proper order of draw for multiple labs to prevent contamination were distributed at this meeting.

**Outcomes**
McCaffrey’s direct communication with the CNO and the work of the task force resulted in a decrease in the percentage of unsuitable specimens requiring redraws for pediatric patients, from 6.70% in February 2018 to:

- 3.43% in July 2018
- 6.55% in August 2018
- 3.03% in September 2018

Evidence TL9EOa-1, WakeMed Health & Hospitals PICU % of Unsuitable Specimens Requiring a Restick to Draw Specimens