

Nursing Competencies in Peds CICU

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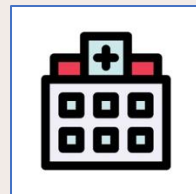
Introductions

Agenda

Hand Hygiene



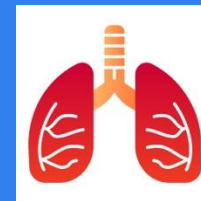
HACs



Central Lines



Chest Tubes



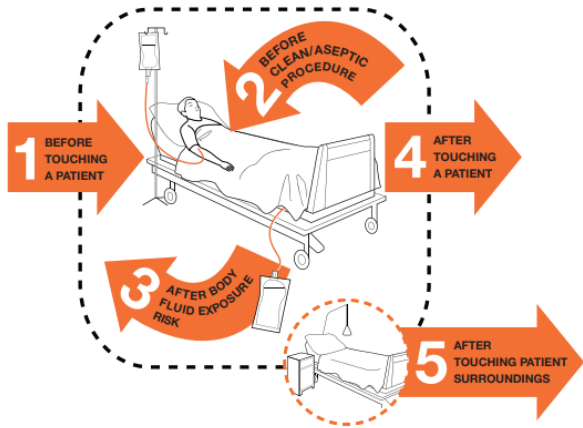
Medication Safety



4

Importance of Hand Hygiene and Infection Prevention

Your 5 Moments for Hand Hygiene



**a clean hand is
a caring hand.**

- Wash hands with soap and water or hand sanitizer
 - Use two pumps from sanitizer dispenser and lather thoroughly
 - Wash for 15-30 seconds
- Don clean gloves
 - **WHY?** Hand antiseptic prevents microbe spread and decreases HAI risks.
- Clean high touch areas- once every shift and prn
 - Counter tops
 - Bed rails
 - IV poles and pumps
 - Mobile meds
 - Bedside tables
 - Computer keyboards
 - Telephones
 - Door handles
 - Sanitizer dispensers
 - Thermometers
 - Wheelchairs
 - Stand up scales
 - **WHY?** High touch areas are heavily contaminated with bacteria.
- Change gloves– Remove dirty gloves between cares, after body fluid exposure, and after touching the patient or surroundings.
 - **WHY?** When gloves are in constant contact with contaminated work surfaces, gloves and hands are dirty
- Perform hand hygiene again





HACs

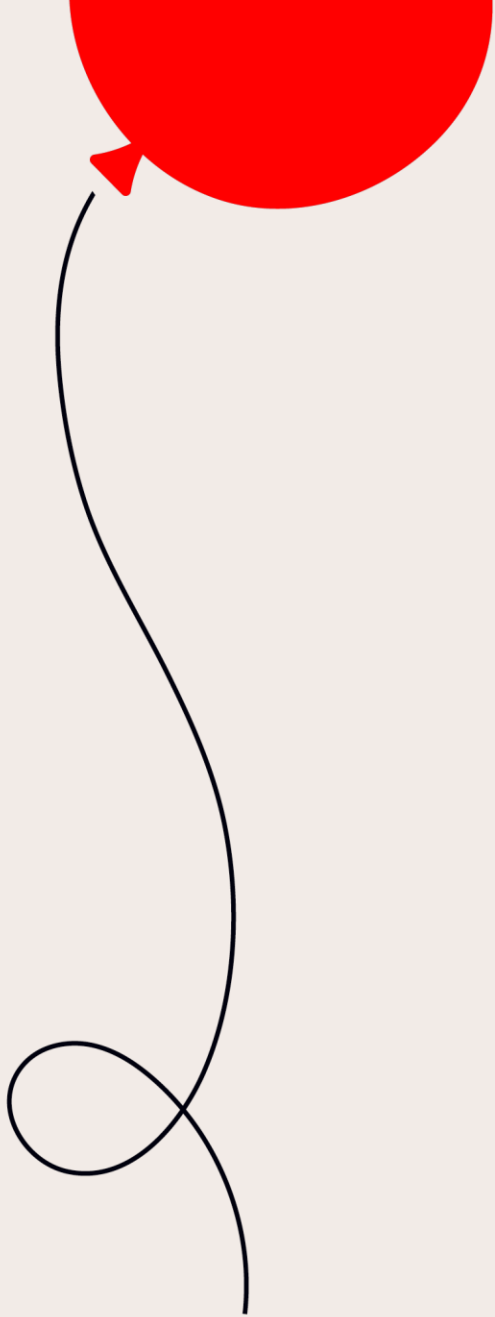
What is it?

Healthcare **A**cquired **C**onditions:

Refers to a medical condition or complication that a patient develops during a hospital stay.

HACs can:

- Cause serious complications for the patient
 - Increase length of stay

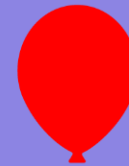


HACs – CLABSI

CLABSI Prevention


What is it?

Central Line Associated Bloodstream Infections



Possible Causes:

- Unclean central line hubs
 - Poor hand hygiene
- Cross-contamination



What is the best way to clean a
central line prior to accessing it?

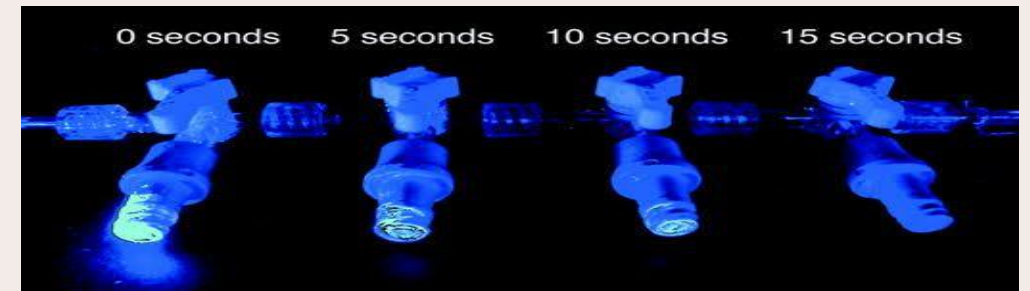
(for labs, giving a medication etc.)



Central Line Management and Care

How can we prevent CLABSIs?

- Change your gloves **OFTEN!!**
- Sterile tubing change
- Line entry: 15 sec scrub with alcohol, 15 sec dry
 - Medication Administration
 - Lab Draws



- Sterile dressing change



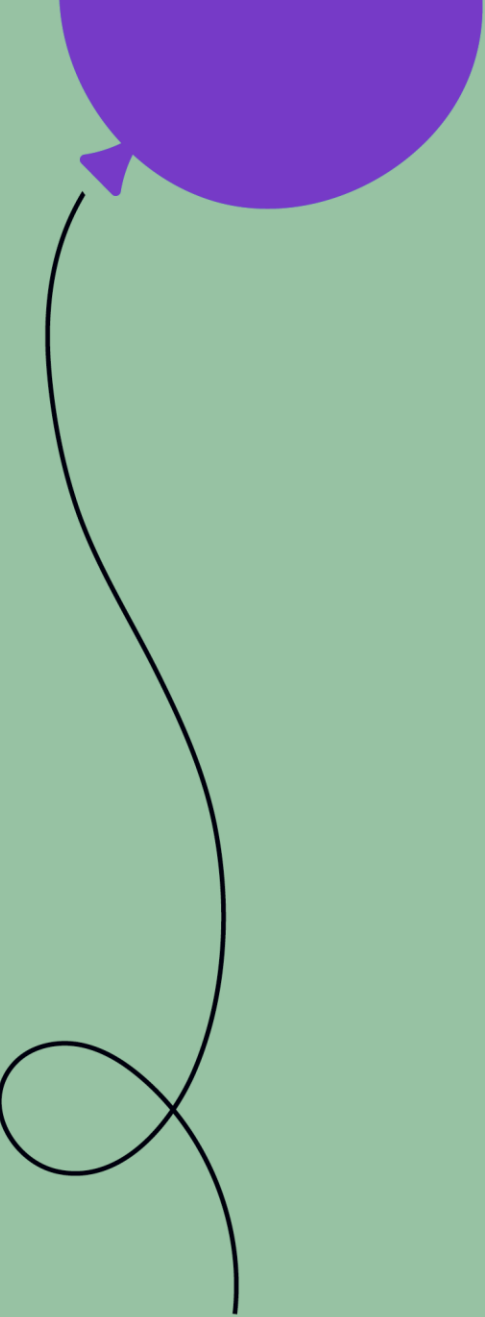
Central Line Dressing Assessment

When to change?

Policy is to change CVLs Q 7 days or prn for PICC lines, however it's necessary to change earlier if:

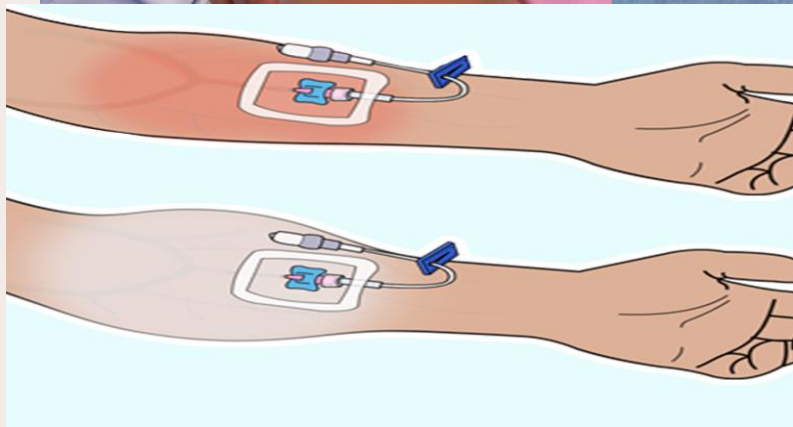
- Dressing is non-occlusive at least 2 cm from the insertion site
- Dressing is lifting and air pocket entered from outside of dressing
- Excessive or Active Bleeding outside of the CHG gel or > 50% of biopatch saturated
- Oversaturated dressing from site drainage or unknown moisture underneath dressing





HACs – PIVIE

PIV Management/PIVIE Prevention



Prevention:

ACT: assess, compare, and touch
Buddy Checks!

- See next slide :)

Armboards, doghouse, tape
When do I flush my line?

- At shift change
- Before you use it for a medication
- After medications have finished
- If you have any worries the IV is no longer “good”

Phlebitis



Our organization defines phlebitis on a scale of 0-4.

0 = No Symptoms

1 = Pain at Access Site

2 = Pain at Access Site with Erythema/Edema

3 = Pain at Access Site with Erythema/Edema, Streak Formation, Palpable Venous Cord

4 = Pain at Access Site with Erythema/Edema, Streak Formation, Palpable Venous Cord >1 in. in Length, Purulent Drainage

Think pain, redness, and swelling!

Infiltration



Signs & Symptoms of Infiltration:

- Swelling
- Flushes with difficulty
- Pain at site
- Skin cool to touch
- Red skin that blanches
- Red and white skin that does not blanch readily
- Skin breakdown or necrosis
- Clear blisters present
- Bloody blisters present
- Capillary refill greater than 8 seconds
- Diminished pulse below site
- Absent palpable pulse below site
- Absent doppler pulse below site

Think color change, swelling, and loss of pulse!

Buddy Checks!



What do you guys do?

What is a Buddy Check?

An independent ACT assessment performed by a second RN on all continuously infusing PIVs.

Who is my Buddy?

Any nurse with comps to assess and document on an IV.

When do Buddy checks happen?

Shift change, twice between 11-3 (halfway through shift), and handoff of care. Primary RN is still responsible for hourly PIV assessments.

Why do I need a Buddy?

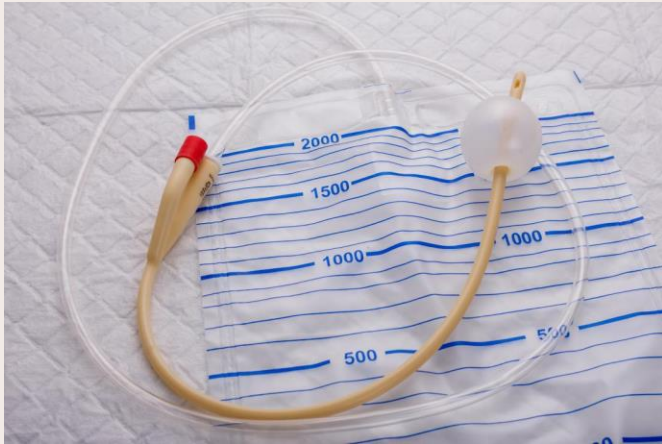
After 6 hours your ability to detect small changes decreases. A buddy is a second set of eyes to help identify infiltrates in early stages, preventing harm to your patient.

How do I document?

We document on our IV flowsheets.

HACs – CAUTI

Urinary Catheter Management/ CAUTI prevention



How do we prevent a catheter infection upon insertion?



1. Does the patient **REALLY** need it?
2. **Completely STERILE** insertion



When inserting a urinary catheter, which of these situations is incorrect?

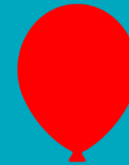
- a) You hold your hands/sterile gloves together above your waste while another nurse helps position the patient
- b) Once cleaning the patient, one hand will be designated as 'not sterile'
- c) Using a sterile hand to adjust the table or bed height for easier insertion



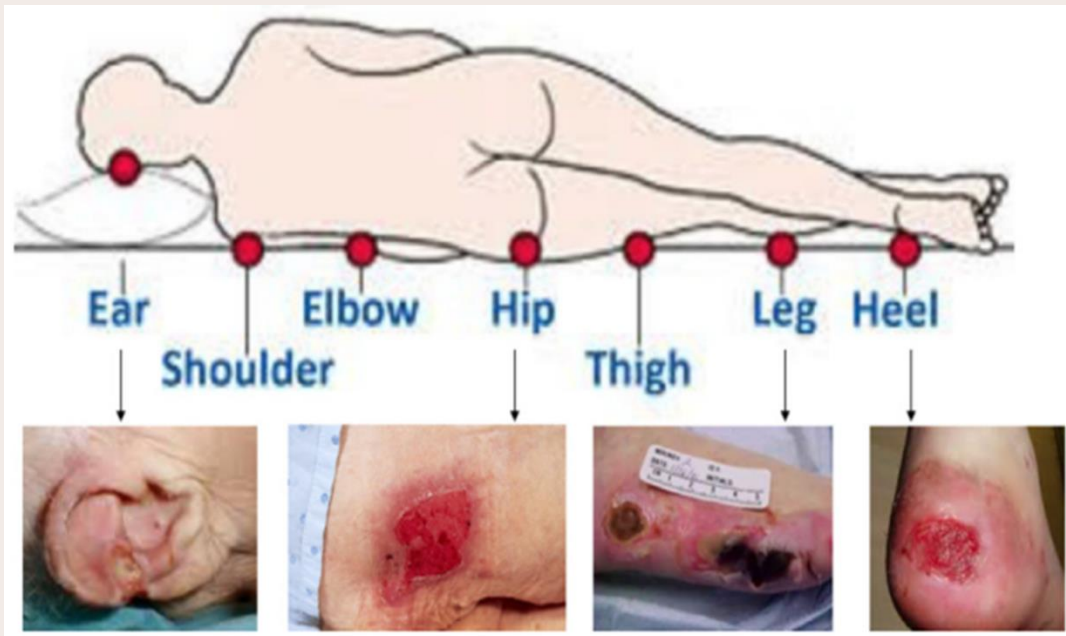
Catheter Maintenance-

- Clean catheter at least once/shift
- EVERY TIME a patient stools, clean with soap and water!
- Make sure it stays a CLOSED system
- Do not hang higher than the patient's bladder
- Secure to leg

HACs - HAPI

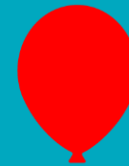


Pressure Injuries/ HAPI prevention



Where can a HAPI occur?

- Sacrum
- Occiput
- Nasal bridge
- Anywhere!



What can cause a HAPI?

- Pulse ox
- Positioning
- Leads
- Bipap
- Caps in bed
- Anything!



Which one of these patients is most at risk for developing a HAPI?

- a) A 12 year old ASD repair from a few days ago who is ambulating to the bathroom with assistance
- b) A 2 month old DORV intubated, on adrenaline and paralyzed
- c) A newborn unbalanced AVC swaddled with head of bed flat
- d) A 4 year old in heart failure sitting in the chair

Pressure Injuries/ HAPI prevention



How do we prevent pressure injuries?

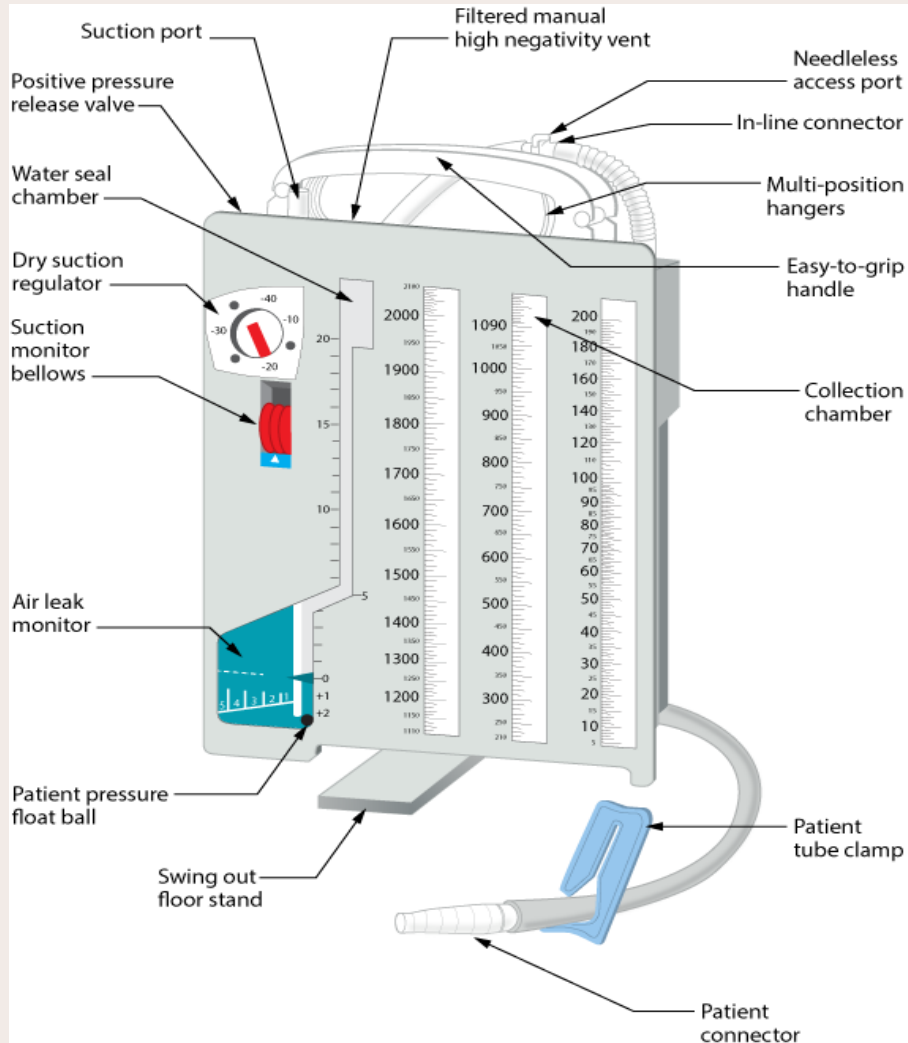
- Rotate the patient at least **every two hours**
- Support pressure points
 - Back of head
 - Sacrum
 - Elbows
- **Minimize moisture**
- Keep cords off the patient's skin
- **Rotate medical devices** regularly (ex: pulse ox, ECG leads, blood pressure cuff)
- Check the bed for loose supplies
- Frequent skin assessments (watch restraints)

Other Safety Topics



Chest Tubes

Chest Tube Management



Why do we have these?

- In the pleural space to remove air, blood or fluid

Key Features and Maintenance

- Water seal vs. Suction
- Intermittent bubbling vs. continuous bubbling
- Positioning (below chest, secure, kinks)
- Regularly output measurements
- Patient assessment

Chest Tube Management 2



Can I walk my patient with a chest tube?


- Yes!
- Water seal, below chest, return to ordered maintenance

Can I milk/strip the chest tube?

- Yes! (this is what we do)
- Why? Clear clots, prevent build-up of fluid in the pleural space
- When? Ordered
- Prevention of:
 - Tamponade
 - Hemothorax

Chest Tube Removal

- Occlusive dressing for 48 hours! (us)
- Purse Strings- leave for 7-10 days!



ET Tubes and UPEs

PROPRIETARY AND CONFIDENTIAL

Unplanned Extubation & ETT Safety



Prevention:

- Restraints
 - Order good for 24 hours
 - Soft wrist for older children
 - Swaddle for infants
 - Nursing Skills: Restraint Slip Knot
- Sedation
 - PRN's available?
 - Pump boluses from current drips or IV
 - Do they settle with a PRN?
 - Current drips—are they enough?
 - ADVOCATE FOR SAFETY
- Measurement
 - Where is your tube located? Double check!
- Have a PLAN!
 - What will it look like if my patient self-extubates? What will I do?
 - Suction + ambu at bedside

What is unsafe?

- Thrashing head around in bed, arching back, and arms reaching toward the tube.
- Tape becoming loose around face and/or tube
 - Heart babies tend to be sweaty and like to vomit which can loosen tape. Movement can also loosen tape.
- Turning, moving, and ambulating alone
 - More is best—> grab another nurse.

Why?

Intubated for a reason...each patient is different. Loss of airway can send patient into respiratory distress to failure and possibly into respiratory arrest.



Which swaddle is the safest to prevent extubation?



1



2



3



Medication Safety

PROPRIETARY AND CONFIDENTIAL

Medication Safety

8 RIGHTS OF MEDICATION ADMINISTRATION:

- Right Patient
- Right Medication
- Right Dose
- Right Time
- Right Route
- Right Reason
- Right Response
- Right Documentation

3 C'S

- Confirm
- Connection
- Clamps

THINK BEFORE GIVING MEDS, AVOID TASK DRIVEN MEDICATION ADMINISTRATION!!!

WHY? → Not just a pill or liquid we give to treat patients, but the medicine we administer can dangerously harm patients if given in error. Could be something small like a drop-in heart rate or something more serious such as death.



TOPIC REVIEW

- Hand Hygiene
- CLABSI Prevention
- PIVIE Prevention
- CAUTI Prevention
- HAPI Prevention
- Chest Tube Management
- Unplanned Extubation
- Medication Safety

thank you

children'shealth?®

