

Background

- When an intermittent infusion is repeatedly disconnected and reconnected for the infusion, there is increased risk of contamination at the spike end, catheter hub, needless connector, and the male luer end of the administration set, potentially increasing risk for catheter-related bloodstream infection
- By minimizing the use of add-on devices for administration sets as each device is a potential source of contamination misuse and disconnections
- Although the incidence of local or bloodstream infections associated with peripheral venous catheters is usually low, serious infection complications produce considerable annual morbidity because of the frequency with which such catheters are used

Practice Change

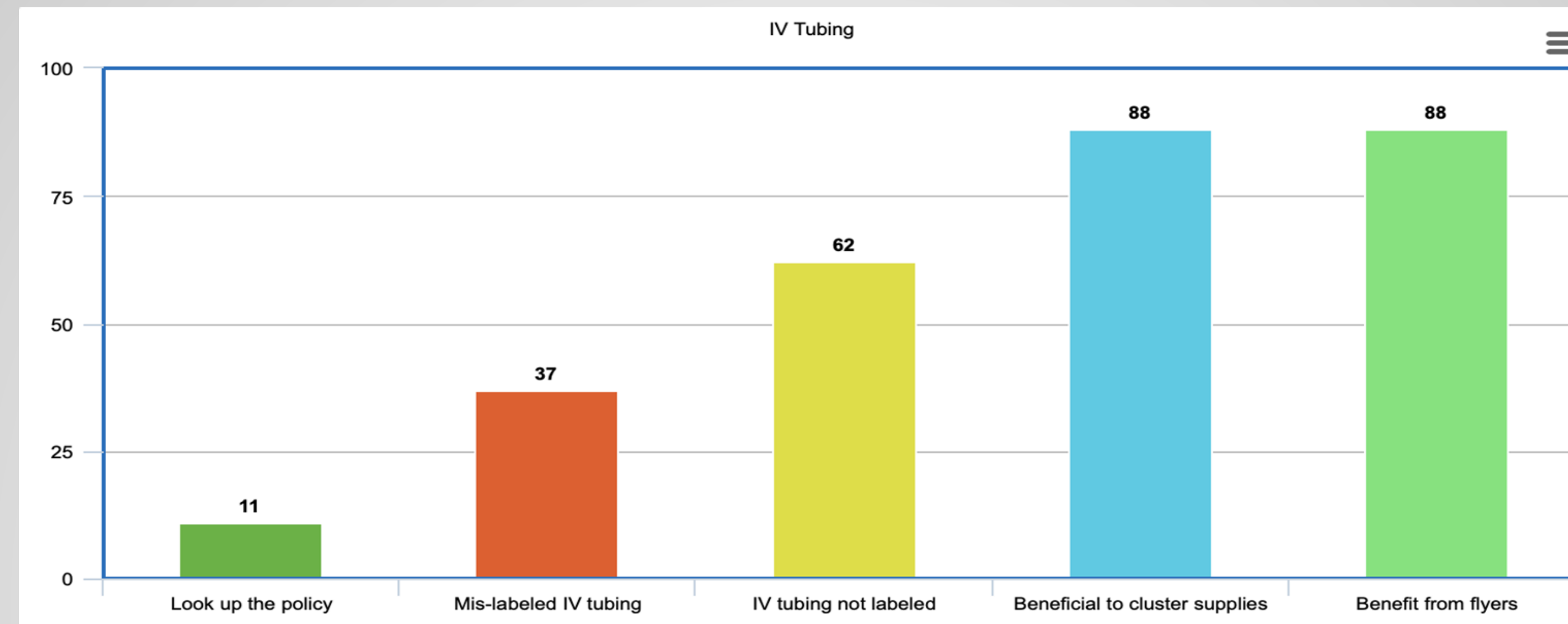
Increase registered nurses' (RNs') knowledge of accurate expiration time frames for different IV tubing through flyers in the med rooms and shift safety huddles

Methods

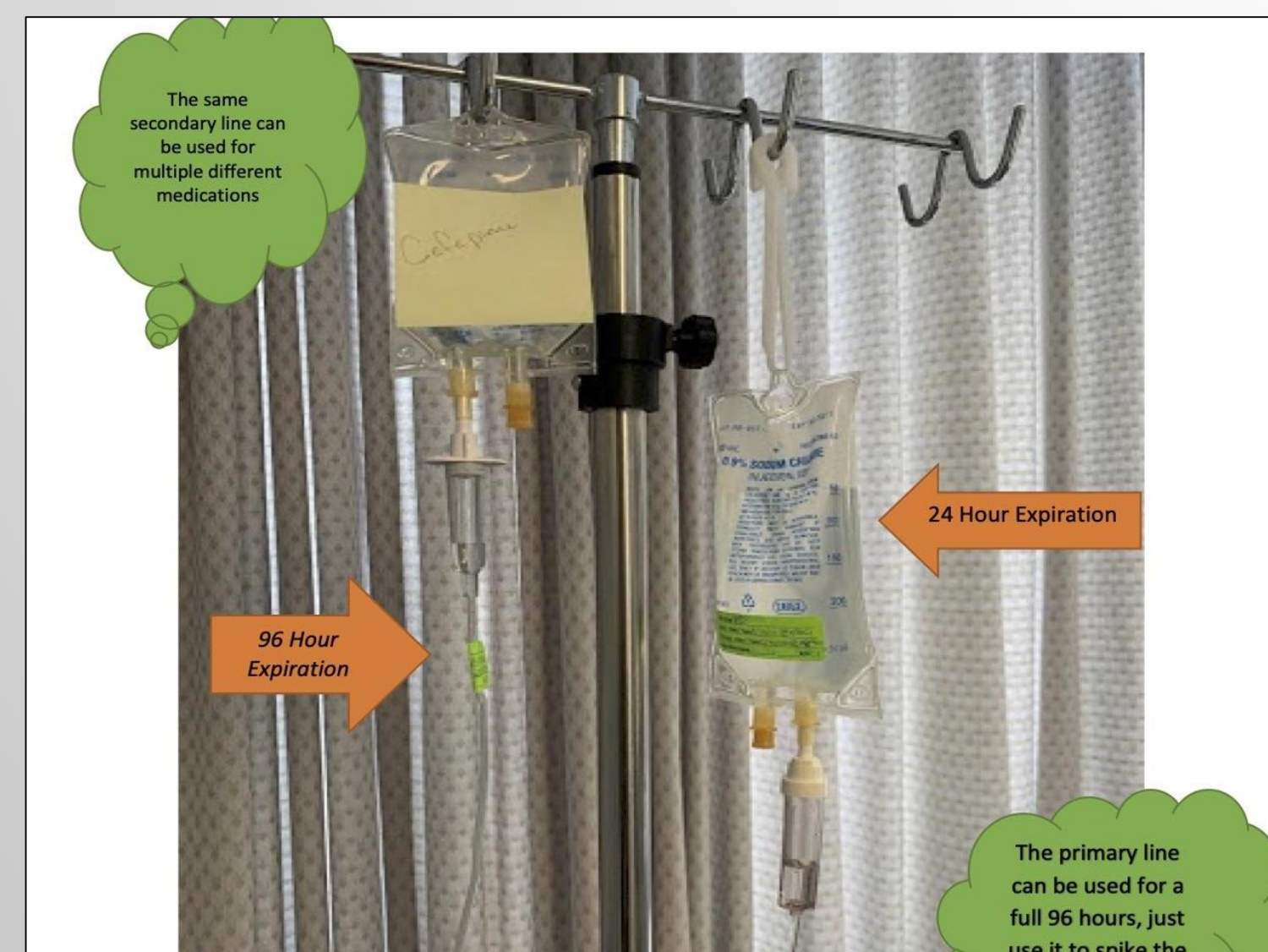
- Administered anonymous paper pre-surveys to RNs
- Presented educational flyers for RN's to review
- Anonymous post-surveys administered two weeks after education

Measures and Results

Pre-Survey Results (n=30)



Educational Flyers



Summary/Discussion

- Next Steps:**
 - Create and implement a diagram to place in medication room
 - Place green labeling and supplies together in supply room for prompting of proper labeling.
- Barriers of this Study:**
 - Lack of time to complete a post survey
 - Lack of feedback from distributed surveys placed on units.
 - Incomplete follow through from management when attempting to group supplies for ease of use.

Conclusion

- Line contamination is a patient safety concern
- Tubing labeling (with change dates and type of fluid) is a standard procedure that can be implemented to increase patient safety
- Implementation of this change process will require more education to staff and managerial support

Patient Safety



References