ICCMU Website Statistics

The growth in Website use experienced during 2006 continued throughout 2007 although the rate of growth slowed. Over the last two years over 119,000 visitors viewed more than one million pages.

In 2006 visitors from 122 countries visited the site whereas in 2007 this had increased to 177. In 2007 the country with the highest ratio of page views per visitor was the United Arab Emirates (44) followed by Australia (22).
International Guidelines

1. European Federation of Critical Care Nursing Associations, European Society of Paediatric and Neonatal Intensive Care and European Society of Cardiology council on Cardiovascular Nursing and Allied Professions: Joint Position Statement

The Presence of Family Members During Cardiopulmonary Resuscitation

http://www.connectpublishing.com/Connects/conf/5.4.1.pdf

2. Surviving Sepsis Campaign

The Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock have been updated using a modified Delphi method incorporating a consensus conference. A complete document is available at the Surviving Sepsis Campaign website.

http://www.survivingsepsis.org/

In addition there are also three presentations (power point shows with audio) from the North American summit held in Denver in November 2007.

- An introduction (19.35min) is given by RP Dellinger and includes some additional background behind the latest set of guidelines;
- A case study is presented by Christa Schoor from Cooper University Hospital where she discusses the real life experiences when implementing the sepsis guidelines; and
- A learning session describing the 'Plan-Do-Study-Act' model of quality improvement is presented by JA Taylor

CLAB ICU Report

• Introduction
The Central Line Associated Bacteraemia (CLAB) ICU project seeks to improve patient outcomes by reducing CLAB through the implementation of a standardised evidence-based guideline for the insertion and management of central lines in NSW Intensive Care Units.

Various initiatives to support the implementation and sustainability of the project are currently in progress. We have provided a brief update below.

• Education and training workshop
As you may be aware, ICCMU and the CEC are facilitating an education and training workshop on 27 February 2008 to progress the development of a standardised education and training resource for central venous catheter insertions in NSW.

It is envisaged that a standardised approach to CVC insertions will result in better outcomes for patients and smoother transitions between units for junior medical staff.

The focus of discussion on the day will be on existing education resources and the scope for e-learning mediums and audio visual aids. To ensure that the resources developed are current and relevant, extensive consultation with you the clinician is essential, particularly if you are involved in training junior clinicians in this procedure.

• Revised checklist
The CLAB ICU checklist has undergone major revision based on your feedback from the November learning session. While it is still a record of the procedure, the emphasis of the checklist is now on compliance with the working policy guidelines. The checklist looks different and has some new additions which we’re sure will peak your interest. It will be accompanied by definitions of key terms which we hope will make completion of the form less ambiguous.

The form is currently being converted to a Teleform compatible format and will be trialled at a number of sites soon.

• Safe Insertion of Central Venous Catheters
  Working policy
The Safe Insertion Working Policy has been revised to include an escalation procedure for junior and senior doctors regarding multiple attempts. It is envisaged that this will be available for release after the next expert group meeting on 27 February 2008.

• Reporting timeframes
Regular reporting is important to embed the processes advocated by the Working Policy and to sustain the project. We have attempted to provide monthly reports to you, however, to accommodate checklists received after the reporting period, reporting has been delayed and on an ad hoc basis.

Rather than delaying the reports, we will now be reporting in the same week each month but reissuing the reports from June 2007 to capture any checklists received after the reporting period.

• Database questions
In response to queries raised during the January teleconferences, Associate Professor Mary Louise McLaws has clarified that central line associated blood stream infections are attributed to the month of insertion in order to reflect the standard of patient safety. While it will always be the case that an occasional CLAB will be detected after the surveillance period, numbers can be adjusted accordingly and the new reporting process that the CEC will apply will accommodate this.

• Of interest
A query came from one of the sites in the last month regarding the use of antiseptic and antibiotic lines. This was of interest for us to explore on a number of levels.

For example it highlighted that a third of the lines in the database do not specify the line coating specifically in reference to antibiotic or antiseptic lines. Feedback at the November learning session suggested that there is some confusion regarding these terms so we have included definitions from a recent review on intravascular catheter-related infections and preventative technology for your information:

- Antiseptic catheters are coated with silver sulfadiazine and chlorhexidine; and
- Antibiotic catheters are coated with minocycline and rifampicin

• Recent publications
This article is available in full text format on CIAP: Raad I, Hanna H, Maki D, 2007, Intravascular catheter-related infections: advances in diagnosis, prevention, and management, Lancet Infect Dis 2007;7:645-57

Don’t forget to check for regular updates at the CEC CLAB ICU website and for further information about the CLAB ICU project please email Margherita Murgo on margherita.murgo@cec.health.nsw.gov.au or Tony Burrell on Burrela@wahs.nsw.gov.au.
Useful Websites:

New from AACN

- **Healthy Work Environments Initiative**
  AACN are committed to improving the working environments for American critical care nurses because it has a beneficial effect for both nurses and patients. To achieve this AACN have developed a set of Standards which are available from a new section of the ACCN Website 'Healthy Work Environments Initiative'. This section has a number of complimentary Links including: Resources; Discussion board; Finding speakers; Happenings; and Research. Under the Resource link you will have access to presentations from NTI national convention, where presentations included innovative solutions to problems such as bariatric patient lifts and finding a place of serenity in Intensive care, as well as a case study of one intensive care that took up the challenge of creating a healthy working environment. A must read resource is 'Silence Kills: the seven crucial conversations for Healthcare'. Which can be found under the Healthy Work Environments-Related Resources From Other Organizations link. However these are but the tip of a large iceberg of information with plenty to offer the Australian Intensive Care environment.

http://www.aacn.org/AACN/hwe.nsf/vwdoc/HWEHomePage

New from AHRQ

Patient Safety Tools: Improving Safety at the Point of Care

AHRQ have released 17 toolkits to improve the delivery of safe effective health care. These toolkits cover a diverse range of clinical areas such as handovers, communication, medication safety, DVT prophylaxis and infection control. These toolkits can be found at the AHRQ site under Quality and Patient Safety.

http://www.ahrq.gov/qual/pips/

New from Joanna Briggs Institute

The 2007 JBI convention: Pebbles of Knowledge: Evidence for Excellence was held in Adelaide where leading Australian and international speakers presented a thought-provoking program which emphasized the connection between research, use of evidence and achieving safe and quality care for patients and consumers. Both plenary sessions and free papers are now at the JBI website. Plenary sessions included:

1. Getting evidence into policy and practice: Perspective of a health researcher, Dr Ian Graham, Vice-President of Knowledge Translation, Canadian Institutes of Health Research, Canada
2. **Evidence, Safety and Quality - how do they link**
   Professor Chris Baggoley, Acting Chief Executive, Australian Commission on Safety and Quality in Health Care, Australia

3. **Getting safety and quality evidence into action.**
   Bill Runciman, President, Australian Patient Safety Foundation, Australia and Professorial Research Fellow, The Joanna Briggs Institute;

4. **The Cochrane approach to systematic reviews**
   Associate Professor Sally Green, Director, Australasian Cochrane Centre, Australia;

5. **Qualitative Evidence Synthesis: Meta-synthesis or metamorphosis.**
   Professor Jane Noyes, Noreen Edwards Chair in Nursing Research, Centre for Health-Related Research University of Wales, Bangor

Warning the download is a touch slow

Put the Biennial JBI Convention on your agenda for 2009, its well worth the trip!

- **From The Medscape Journal of Medicine**
  - **Webcast Video Editorials**
    → **Esoteric or Exoteric? Music in Medicine**
    Report of a RCT where the effects of a selection of Mozart on the stress levels of critically ill intubated adults. Measurements of stress hormones, cytokines and physiological parameters were made whilst patients were off sedation

**Quality**

- **Eating Soup with a Spoon**
  This presentation is an 'on-demand streaming video' presentation delivered by Donald M. Berwick, MD, MPP, who is the President and CEO of the Institute for Healthcare Improvement (IHI). You will need to register however its FREE. Dr Berwick covers the habits of good care and the principles for improving them as well as developing a culture of improving care across an organisation.
  http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationBerwick.htm?TabId=2

**New at NSWHealth**

- **Policy, Directives and Guidelines**
  1. Leave entitlements and flexible work arrangements to observe religious duties (GL2008-003)
  2. Triage of patients in NSW Emergency Departments (PD2008_009)
  3. Closed Head Injury in Adults - Initial Management (PD2008_008)


- **Lessons learnt on Quality and Safety**
  Learn from previous incidents by reviewing the Case studies that have been posted under the following topics
  1. Falls prevention
  2. Blood administration
     a. Wrong blood transfusion
     b. Wrong patient transfusion
  3. Maternal and perinatal
  4. Correct site procedures
  5. Clinical management
     a. Fine bore NG in neurosurgical patient
     b. Response to a deteriorating patient
     c. IABP


- **Safety Alert Broadcast System**
  1. Oxycodeone - Feb 5 2008
  2. TGA recalls - Jan 31 2009
  3. Pulmonary Embolism Diagnosis in Young People - Jan 29 2008
  4. TGA recalls - Jan 16, 2008
  5. TGA recalls - Dec 3, 2007

**In-services:**

Has your unit had an inservice yet? Do you want another inservice?

Please contact: Kaye Rolls

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Sorry for NSW & ACT members only