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Implementing Bedside Regional Anesthesia: Improving Clinical Effectiveness

A mobile regional anesthetic service is effective in reducing delays in delivering regional anesthesia to patients and improves efficiency of the acute pain service.
Implementing Bedside Regional Anesthesia: Improving Clinical Effectiveness

Geoffrey Ho M.B.B.S., Everett Chu M.D., Adam Greenwood M.D., Jason Podolnick M.D., Natalie Pudalov B.A., Philip T.H. Dela Cruz B.S., Paul Dangerfield M.D.
Department of Anesthesiology and Critical Care Medicine, George Washington University School of Medicine and Health Sciences, Washington D.C.

BACKGROUND

- The opioid epidemic poses challenges for inpatient pain management
  - Nerve blocks reduce opioid usage in acute pain
  - Improved patient satisfaction
  - ↓↓ opioid side effects & addiction risk
- Blocks had to be done in post-anesthetic care unit (PACU) or Intensive Care Unit
  - Delays were due to lack of transport, PACU beds etc.
- Acute Pain Service (APS) unable to meet ↑↑ demand for blocks

OBJECTIVES

- In October 2018, we started planning a ‘Mobile Block Team’ (MBT) with the goals of:
  - Reducing delays to block non-perioperative patients
  - Improving efficiency of the Acute Pain Service

METHODS

- In January 2019, we piloted the MBT, comprising of:
  - Attending Acute Pain Anesthesiologist
  - Anesthesiology Resident
  - 2 Registered Nurses
  - Safety protocols agreed with Nursing Leadership
  - Equipment: 2 backpacks, portable ultrasound & monitor
  - Success of service assessed in two phases
    - Phase I – Prospective case-control
    - Phase II – Retrospective Analysis

METHODS (CONTINUED)

- Identified stakeholders
- Identified delays to block
- Scanned Acute Pain Service
- Reassessed was delays were non-clinical
- Created Mobile Block Team (MBT)
- Consulted Nursing Leadership and Pharmacy
- Equipment: 2 backpacks, portable ultrasound & monitor
- Residents monitored for 30mins post
- Block performed
- Advertised to Department
- Use of MBT encouraged
- Test ability of MBT to improve efficiency
- Compare number of procedures done before and after implementation
- Retrospective analysis proves improved efficiency
- Increase this intervention to other pain services

RESULTS

- Phase I
  - PACU block delays triple Mobile blocks
  - 61 minutes vs 19.5 minutes (p = 0.004)
- Phase II
  - Average increase of 217% in non-perioperative blocks per month (6.7 to 20.9; p = 0.009)
  - Average increase of 55% in total blocks per month (138.3 to 215; p = 0.004)

CONCLUSIONS

- Bedside blocks reduced waiting time for patients needing blocks
- Improved efficiency translated to more blocks done overall
- Successful program that is replicable in other institutions

ACKNOWLEDGEMENTS

All Hands-on Deck: Use of Comprehensive Interventions to Reduce VTE Rates in an Academic Medical Center

MedStar Georgetown University Hospital

Hanan Foley MSN, RN, CPHQ; Elizabeth Freedman, MPH; Kerry Gray, MS, BSN, RN; Jane Snyder, MBA, RN, CPAN, CPHQ

Hospital-Acquired VTE rate reduction can be attained through multidisciplinary engagement, collaboration and consistency of communication.
All Hands on Deck: Use of Comprehensive Interventions to Reduce VTE Rates in an Academic Medical Center

Hanan Foley MSN, RN, CPHQ; Elizabeth Freedman, MPH; Kerry Gray, MS, BSN, RN; Jane Snyder, MBA, RN, CPAN, CPHQ

Background / Aim

Venous-thromboembolism (VTE), is a serious health complication affecting over 900,000 people a year in the United States and is a leading cause of preventable death in the acute care setting.

The impact of VTE on the affected patient is of the highest priority. It can lead to delayed discharge, higher risk of reoccurrence, post-thrombotic syndrome as well as potentially prolonged treatment and procedures.

A multi-disciplinary VTE Prevention Task Force comprised of providers, nurses, quality staff, informaticists, pharmacists and data analysts to address this issue.

Goal: To evaluate VTE care, identify root causes and develop interventions and practice changes to lead to an overall reduction in hospital acquired VTE rate and patient harm.

Objectives

1) Identify root causes contributing to hospital acquired VTE rates.
2) Describe the various interventions and practice changes that were put in place to address the identified root causes.
3) Identify transferrable interventions that may impact processes and outcomes at your organization.

Methods

Given the complexity of the problem, a multi-faceted approach utilizing different performance improvement tools at different stages was adopted.

A "post VTE debris" process was established. This was supported by the radiology department sending the quality team an automatic e-mail alert for all critical findings of VTE upon identification. A real-time review of the medical record and discussion of the case with the involved providers and nursing staff followed. As themes emerged, the taskforce was able to promptly identify root causes and prioritize action plans.

Interventions

- Patient targeted VTE education material highlighting wearing SCDs a minimum of 18 hours per day.
- Ensuring a SCD machine dedicated to each hospital bed to reduce delay in availability.
- Piloting and adopting new comfort sleeves to increase patient compliance with SCD treatment.
- Physical medicine and rehab (PM&R) staff adding reapplication of SCD’s after therapy to their workflow checklist.
- Piloting and adopting new comfort sleeves to increase patient compliance with SCD treatment.
- Patient targeted VTE education material highlighting wearing SCDs a minimum of 18 hours per day.
- A specific electronic power-form was developed that allowed both the Interventional Radiology (IR) and Gastroenterology (GI) teams to communicate, via informaticists, pharmacists and data analysts to address this issue.
- A multi-disciplinary VTE Prevention Task Force comprised of providers, nurses, quality staff, informaticists, pharmacists and data analysts to address this issue.
- The impact of VTE on the affected patient is of the highest priority. It can lead to delayed discharge, higher risk of reoccurrence, post-thrombotic syndrome as well as potentially prolonged treatment and procedures.

Results

The neurosurgery department has achieved 46.12% reduction in hospital acquired VTE from FY19 to FY20 (through March)

Conclusion

Interventional Radiology Per-Procedural Communication Plan Preliminary Results:

- Between January and October 2019, there were 1638 unique in-patients who had an IR procedure - 41 of them had a hospital acquired VTE for a rate of 2.50%.
- Between November and December 2019, there were 349 patients who had an IR procedure - 6 of them had a hospital acquired VTE for a rate of 1.72%.
- This represents a statistically significant 30% reduction.

References


We have achieved a 26% reduction in hospital acquired VTE from FY19 to FY20 (through March) among inpatients, age 18+.
Collaborative Approach to Improving Organization-Wide Safety Culture

Sakamoto, Y., MHA; Martorana, J., BSN, RN, CPN, CPEN; Merkeley, K., MHSA, BSN, RN; Fahey, L., MSN, RN; Shah, R., MD, MBA

Safety Culture Improvement Partners’ collaborative approach turned safety culture survey results into meaningful, sustainable actions that cultivate improvements reaching patients, families and staff.
Collaborative Approach to Improving Organization-Wide Safety Culture

Sakamoto, Y., MHA; Martorana, J., BSN, RN, CPN, CPEN; Merkeley, K., MHSA, BSN, RN; Fahey, L., MSN, RN; Shah R, MD, MBA

Background

Safety culture surveys provide valuable insight into workforce perception of safety culture; however, organizations experience competing priorities and limited resources, making it challenging to utilize results to drive meaningful culture change. The inception of Safety Culture Improvement Partners (SCIP) sought to develop and test a collaborative approach tailoring improvements to the unique safety culture needs of departments across the organization.

Objectives

1. Create a framework for programmatic and collaborative approach to improving culture.
2. Identify pilot SCIP teams.
3. Develop and implement department-specific action plans.

Methods

SCIP utilizes existing resources and aligns patient safety methodology and tools with frontline expertise for a collaborative approach to safety culture improvement (Figure 1). 2018 safety culture survey data was used to identify 8 SCIP teams. Patient Safety (PS) Consultants paired with SCIP teams to identify domains for improvement, incorporate existing operational priorities, and provide additional tools or consultative services such as process mapping, observations, surveys, and facilitated feedback sessions to create individualized action plans (Figures 2-4). Action plans are fluid and continued support is provided to SCIP teams through structured check-ins, outcome tracking, and resources for continuous improvement.

Results

Over 20 department leaders and 80 frontline staff were involved in developing action plans. To date, 20 safety culture interventions have been completed. Action plan implementation and sustainment is underway. SCIP participants will complete a pulse check survey in June 2020 and the safety culture survey in late 2020. Actions will be evaluated for spread to other areas of the organization.

Conclusions

SCIP’s collaborative approach has turned safety culture survey results into meaningful, sustainable actions that cultivate improvements reaching patients, families, and staff. Frontline staff, with direction from departmental leaders and PS Consultants, developed solutions addressing safety culture challenges. These solutions and best practices could be shared and spread across the organization.
Occupational Therapy’s Role in 3D Printing

Bronze

MedStar National Rehabilitation Network

Megan L. Mahaffey, MOT, OTR/L, ATP

3D printing is a beneficial resource for OTs and other clinicians to use to create adaptive devices that are low cost, quick to fabricate, customizable, lightweight, and easy to replicate to maximize a client’s independence and safety.
Occupational Therapy’s Role in 3D Printing
Megan L. Mahaffey, MOT, OTR/L, ATP
MedStar National Rehabilitation Hospital, Washington DC

What is 3D Printing?
- Additive process using layers that are stacked on top of each other to create an object
- Fused deposition modeling (FDM) or fused filament fabrication (FFF) is most common form of 3D printing
- Layers of meltable materials, such as thermoplastics, are extruded from printer on top of each other
- Common materials (filament) used in 3D printing are:
  - Acrylonitrile butadiene styrene (ABS): petroleum based material similar to lego material
  - Polyactic acid (PLA): plant based material similar to plastic cutlery
  - Thermoplastic polyurethane (TPU): elastic polymer material similar to a rubber mat

How does 3D Printing Work?
- Design with computer assisted design (CAD) software
- Download from 3D printing database
- Observed from 3D printing database and modify using CAD software
- FDM printing
- Common file types are STL and OBJ

Pros of 3D Printing:
- Cost effective per item
- Customization for patient needs
- Easy to print multiple items once printed before
- Set it up and leave it

Cons of 3D Printing:
- Size constraints of build plate
- Time consuming
- Cannot be modified after printed
- New technology with some kinks
- Initial cost of printer
- Patience is required
- Rough surfaces

How Can 3D Printing Be Used in Occupational Therapy?
- Create an object quickly to meet a time sensitive need for a client (see example 1)
- Reproduce an item that may no longer be available or comes at a high cost (see example 2)
- Customize devices to meet a unique client need or create something a client would be unable to buy off the shelf (see example 3)
- Replace or repair broken equipment or broken piece of a device

Client Examples for 3D Printing

Example 1:
Client 60 year old male with a history of an incomplete spinal cord injury greater than 30 years. Client uses a scooter, manual wheelchair and lofstrand crutches for mobility. Pt previously had a small tray on the back of his manual wheelchair where he rested his lofstrand crutches. This allowed him to easily transition from propelling his wheelchair to ambulation. Recently, he has required larger tips for lofstrand crutches and they no longer fit in the tray. Within a few hours, the client’s occupational therapist was able to design and 3D print a new tray that fit his crutches and was able to be attached by screws to manual wheelchair.

Example 2:
Client is a 17 year old male with Duchenne Muscular Dystrophy. He presents with increased tone in bilateral upper extremities and decreased fine and gross motor coordination. Client has limited verbal output and is usually only understood by family and frequent caregivers. He primarily communicates with head nods and head shakes. Client recently has acquired an augmentative and alternative communication device (PRC Accent 1000) with a key guard. The client is very resistant to using it. The device and keyguard are set up for 64 items on a page. His occupational therapist observes that targets are small and hard for him to hit accurately. He becomes easily frustrated and abandons his device. The device can be set up to offer only 15 items on a page at a time. While this limits his communication options, it significantly increases the size of the targets. Both the client and his mother are open to trying this option. Since the client often drops his fingers across the screen to desired target, a keyguard is very helpful to prevent selection of wrong item. His old keyguard will not work with the larger targets. One can be found online for about $30. It had not been determined if having only 15 items would on the screen would work for him, so his occupational therapist decided to design and 3D print a new keyguard for him.

Example 3:
Client is a 50 year old female with Guillain Barre Syndrome. She presents with limited active range of motion in bilateral upper extremities and fatigues quickly. She is strongest in her biceps and has limited verbal output and is usually only understood by family and frequent caregivers. He primarily communicates with head nods and head shakes. Client recently has acquired an augmentative and alternative communication device (PRC Accent 1000) with a key guard. The client is very resistant to using it. The device and keyguard are set up for 64 items on a page. His occupational therapist observes that targets are small and hard for him to hit accurately. He becomes easily frustrated and abandons his device. The device can be set up to offer only 15 items on a page at a time. While this limits his communication options, it significantly increases the size of the targets. Both the client and his mother are open to trying this option. Since the client often drops his fingers across the screen to desired target, a keyguard is very helpful to prevent selection of wrong item. His old keyguard will not work with the larger targets. One can be found online for about $30. It had not been determined if having only 15 items would on the screen would work for him, so his occupational therapist decided to design and 3D print a new keyguard for him.

References
Evaluation of a Pharmacist-Driven Vancomycin Dosing Service in an Urban Academic Medical Center

Mary Taylor, PharmD, BCPS; Adetokunbo Adedokun, MPH, BCPS, PharmD2; Amanda Valentine, M.Eng, MSHI

Clinical Pharmacokinetic services optimized vancomycin dosing and improved therapeutic trough attainment.
Evaluation of a Pharmacist-Driven Vancomycin Dosing Service in an Urban Academic Medical Center

Mary Taylor, PharmD, BCPS, Adetokunbo Adedokun, MPH, BCPS, PharmD² Amanda Valentine, M.Eng, MSHI
Howard University Hospital

INTRODUCTION

Achievement of therapeutic serum levels, appropriate dosing regimens, and de-escalation of therapy are critical when treating patients with pathogens that may have reduced susceptibility to antibiotics. Sub-therapeutic vancomycin exposure may result in treatment failure and non-de-escalation may cause the emergence of vancomycin-resistant pathogens. Pharmacy-directed vancomycin dosing and monitoring may improve safety and outcome. This evaluation will assess the appropriateness of vancomycin monitoring in pharmacy consult patients and non-pharmacy consult patients.

Outcome

There were a total of 110 patients evaluated. Twelve patients met the exclusion criteria. The Pharmacist-led Clinical Pharmacokinetics Service received 55 consults and non-pharmacy consults totaled 43 patients. The most common indications included: sepsis or bacteremia (47%), followed by pneumonia (22%). A trough was obtained in 100% of patients being managed by the consult service compared to 67% of patients in the non-pharmacy consult patients. The Pharmacist-led service achieved a therapeutic trough in 60% of patients and the non-consulted patients achieved a therapeutic trough 45% of the time. For each patient with a subtherapeutic or a supratherapeutic trough, the dose was changed in 100% of the consult service patients compared to the dose being changed in 25% of non-pharmacy consult patients.

CONCLUSIONS

Our study demonstrated that Clinical Pharmacokinetic services optimized vancomycin dosing and improved therapeutic trough attainment. The goal of the pharmacy department is to provide Clinical Pharmacokinetic services to all patients receiving vancomycin. In addition, we are working with the Informatics Pharmacist to develop order sets that will provide better guidance to providers on correct vancomycin dosing and trough monitoring. Finally, we plan to continue ongoing evaluation of the Clinical Pharmacokinetic Service, to ensure continued improved outcomes.

Aim

To ensure optimal vancomycin dosing, monitoring and administration at an urban, academic medical center in Washington, D.C.

Project Design/ Strategy

Patients with vancomycin orders were identified in a computerized physician order entry system, Soarian®. Data collected included indication, culture data, and pharmacokinetic parameters. Monitoring data collected included initial and maintenance vancomycin dose and frequency, trough, and time of trough.

Actions Taken

A Pharmacist-led Clinical Pharmacokinetics Service and a standardized protocol for dosing and monitoring vancomycin in adult patients were established. Per the Pharmacy and Therapeutics approved “pharmacy to dose” policy, pharmacists are able to write orders and change doses, as well as order serum concentration levels, and relevant labs. Extensive education was provided to the Clinical Pharmacists. To ensure competence, an annual competency exam is administered to all clinical pharmacists. The pharmacist is deemed competent in vancomycin dosing if a passing score of 70% is achieved. A pharmacy vancomycin consult note was developed to ensure consistency with documentation in the patient’s medical record. Required parameters include: clinical indication, height, weight, serum creatinine, concurrent antimicrobial therapy, most recent serum drug concentration, microbiology results and anticipated length of therapy.

CONTACT

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Email: avalentine@huhosp.org

Pharmacy Vancomycin Consults Vs. Non-Pharmacy Vancomycin Consults

<table>
<thead>
<tr>
<th>Pharmacy Vancomycin Consults n=55 (56%)</th>
<th>Non-Pharmacy Vancomycin Consults n=43 (44%)</th>
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<tbody>
<tr>
<td>Male = n=36 (65%)</td>
<td>Male = n=20 (46%)</td>
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<td>Female = n=25 (45%)</td>
<td>Female = n=13 (30%)</td>
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<tr>
<td>Avg age = 67 y/o</td>
<td>Avg age = 59 y/o</td>
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Pharmacy Consult Service Vs. Non-Pharmacy Consult Service

- Trough Obtained
- Therapeutic Trough
- Dose Changed due to sub/supratherapeutic trough

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<tr>
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<th>Pharmacy Consult</th>
<th>Non-Pharmacy Consult</th>
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<tr>
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Bronze

Empowering Rehabilitation Therapists to Prevent Hospital Readmissions for Uninsured Population

A retrospective study of the uninsured population gives initial indication that increasing frequency of therapy may help reduce readmission to allow those without insurance to remain in the community.

Michelle Solan, OTR/L, CBIS; Amy Phillips, PT, DPT; Anne Marie Popgoshev, OTR/L, CBIS; Natasha Chevalier Richards, PT, DPT, NCS, CBIS
Empowering Rehabilitation Therapists to Prevent Hospital Readmissions for the Uninsured Population
Michelle Solan, Amy Phillips, Anne Marie Popgoshev, Natasha Chevalier-Richards

Background
- 27.5 million people in the US and 22,000 people in DC are uninsured.
- Overall uninsured hospital patients have shorter lengths of stay (LOS), receive less therapy, and have limited access to rehabilitation after discharge.
- Functional impairments are a barrier to discharge for the uninsured at GWUH, causing increased LOS.
- Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) intervene on patient’s functional impairments.
- 2018-2019: GWUH Rehab developed a Clinical Specialist role and implemented new communication routines to facilitate safe discharge to the community for uninsured patients.

Objectives
Goal: Determine the impact of increasing access to hospital-based rehabilitation services for people who are uninsured.
- Describe the role of therapy in the uninsured population.
- Determine if increasing rates of therapy visits contributes to improved health outcomes as defined by fewer hospitalizations for the population of uninsured patients.
- Identify reproducible therapeutic strategies to facilitate safe discharge planning for an uninsured patient.

Methods
- Retrospective study on patients admitted to GWUH in 2018 and 2019 comparing number of admissions, number of uninsured admissions, and number of admissions with therapy services.
- Compared the average LOS between the insured and uninsured patients admitted to GWUH in 2019 using a single factor ANOVA.
- Compared the number of uninsured patients with LOS >5 days who received therapy services to those who did not receive therapy. LOS >5 represents a greater than average LOS and a broad indicator of higher medical complexity.
- Readmission is defined as any admission to GWUH within 90 days after a previous discharge from this hospital, and in order to study the effect of therapy services on readmission we compared the percentage of patients who were readmitted for uninsured patients with LOS >5 days who received therapy to those who did not receive therapy.
- We used a case study format to look at 2 uninsured patients with LOS >5 days who received therapy services. Clinical Specialists identified aspects that promoted successful discharge to the community. The patients were rated using the Functional Independence Measure (FIM), an 18-item tool used to assess a patient’s level of disability, as well as change in patient status in response to rehabilitation or medical intervention. Lowest score per task is 1, which means a helper provides up to 75% assistance. Highest score per task is 7, which means a helper provides 0% assistance.

Results

- Number of Uninsured Admissions 2019
- Percentage of Readmissions for Patients with LOS >5, 2018-2019
- Total Number of Therapy Units Received by Uninsured patients with LOS >5 days

Patient 1: Mr. T
- 57 year old male who survived acute hemorrhagic stroke
- Clinical Specialists provided: more frequent therapy, mentorship to other therapists in advanced rehab techniques, and advocacy for charity services
- Med-Surg Admission: requires up to 100% assistance from 2 people
- Acute Rehab Admission: requires >25% assistance from 1, admitted to Acute Rehab
- Discharge to Community: returned home without requiring physical assist

Patient 2: Mr. P
- 47 year old male who survived acute hemorrhagic stroke
- Clinical Specialists provided: more frequent therapy, advanced rehab techniques, mentorship to other therapists in advanced rehab techniques
- Med-Surg Admission: requires up to 75% assistance from 1 person
- Discharge to Community: returned home without requiring physical assist

Conclusion
Rehabilitation therapists use a unique approach to facilitate discharge for uninsured patients who remain in the hospital longer than average due to complexity of deficits, limited social support, unreliable housing, and other barriers. A retrospective study of the uninsured population at GWUH gives initial indication that increasing frequency of therapy may help reduce readmission to allow those without insurance to remain in the community. A corresponding case study reveals aspects of a plan that can expedite interdisciplinary planning for safe discharge.

- Rehabilitation Clinical Specialist: implements “rehabilitation in place” using clinically advanced techniques, providing increased frequency and length of treatment sessions, advocacy for further charity rehabilitation when appropriate, and mentorship to therapists working through barriers to discharge brought on by lack of insurance.
- Communication routines implemented 2018-2019: hospital wide interdisciplinary rounds, quick identification of uninsured and underinsured patients among relevant therapists, use of HIPAA compliant messaging applications, and deployment of work phones across several departments.
- Limitations: retrospective study and case study with no control group; limited scope (2018-2019); the use of LOS >5 as a marker of more medically complex patients leaves confounding variables including the possibility that some patients with LOS >5 may not be relatively more complex; no further refinement of population by diagnosis or comorbidities when studying risk for readmission; among others.

References
Honorable Mention

Transitions of Care Outcome Tool - Identifying Unmeasured Metrics, Reducing Provider Redundancy, and Allocating Limited Resources

Drs. Mary Barrow, Jonathan Tran, Vicky Zhu, Joanna Lyon

Successful transitional care, especially prior to hospital discharge, is essential for improved patient outcomes and possible cost-savings for health care systems.
TOCOT: Transitions of Care Outcome Tool
Identifying unmeasured metrics, reducing redundancy, and allocating resources

Mary Barrow, Jonathan Tran, Vicky Zhu, Dr. Joanna Lyon
Special thanks to Dr. Eric Pitts, Director of Pharmacy at Medstar National Rehabilitation Hospital, for his support and collaboration on this project

Institutional Review Board approval was obtained from the MedStar Health Research Institute (STUDY00000975)

TOCOT Implementation

The NRH Pharmacy department initiated a performance improvement program by collaborating with the University of Maryland School of Pharmacy. The overall goal of this project was to strengthen the protocols surrounding patient discharge and help ensure the best medication regimens were provided to patients at this critical Transitions of Care juncture. Medication reconciliations were followed by individualized patient education sessions, which involved creating educational materials targeted toward the patient’s cultural background and health literacy levels, as well as addressing patient questions/concerns and resolving final discharge issues. After each education session, pharmacist-team actions were documented with TOCOT for further evaluation.

● TOCOT pilot time period was from May 4, 2018 to June 14, 2019
● Outcomes included 2558 clinical pharmacist interventions for 210 qualifying patients (Table 2a)

Inclusion criteria: patients over 18 years old, not pregnant, able to give informed consent for the program, and discharged within the pilot time period

There were an average of 12 interventions per patient documented.*

*Interventions were defined as actions by the pharmacy team to educate, clarify, or resolve a specific patient medication issue that was deemed significant enough to impact patient safety or satisfaction.

TOCOT data identified areas in which pharmacist-team interventions can streamline the clinical workflow by relieving the healthcare redundancy and burden from physicians, nurses, and case managers, as depicted in Table 2b. Although the majority of the Transitions of Care interventions were indeed fundamental pharmacist activities, a surprising 30.5% of the interventions reduced the burden on physicians, nurses, and case managers by performing valuable and time-consuming functions, while 5.8% of the interventions assisted in the interdisciplinary cohesion and functioning of the healthcare team approach.

TOCOT was developed based on an identified need to accurately record actionable opportunities for patient safety during the Transitions of Care process

TOCOT was piloted at NRH to track and analyze the value of Transitions of Care processes and interventions

Data from TOCOT was evaluated to determine target medication safety needs and educational opportunities to improve healthcare collaboration and the culture of safety at NRH.

TOCOT data analyzed provided multiple program improvement opportunities and outcomes. A TOCOT Powerform is being built in the Cerner EHR system for increased data access and possible further program expansion in the MedStar hospital system.

Overview

PDCA Cycle

<table>
<thead>
<tr>
<th>PDCA Cycle</th>
<th>TOCOT was developed based on an identified need to accurately record actionable opportunities for patient safety during the Transitions of Care process</th>
</tr>
</thead>
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Table 2a. Intervention Outcomes

<table>
<thead>
<tr>
<th>Intervention Category</th>
<th>Percent of Total Interventions</th>
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</thead>
<tbody>
<tr>
<td>A - Supporting Compliance</td>
<td>39.7</td>
</tr>
<tr>
<td>B - Side Effect Counseling</td>
<td>16.0</td>
</tr>
<tr>
<td>C - Specialized Medication Education</td>
<td>8.2</td>
</tr>
<tr>
<td>D - Clinical Medication Questions</td>
<td>8.7</td>
</tr>
<tr>
<td>E - Developing Strategies for Non-Traditional Dosing</td>
<td>6.7</td>
</tr>
<tr>
<td>F - Error Prevention with Home Medications</td>
<td>2.5</td>
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<tr>
<td>G - Addition or Dose of Medications</td>
<td>2.4</td>
</tr>
<tr>
<td>H - Drug Monitoring Education</td>
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</tr>
<tr>
<td>I - Non-Pharmacologic</td>
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</tr>
<tr>
<td>J - Final Health Team Consultation</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Table 2b. Interventions per Pharmacy Service Categories

<table>
<thead>
<tr>
<th>Pharmacy Service Category</th>
<th>Percent of Total Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Pharmacist Intervention</td>
<td>63.7</td>
</tr>
<tr>
<td>Interventions Performed by Pharmacist that Reduced Physican Burden</td>
<td>20.3</td>
</tr>
<tr>
<td>Interventions Performed by Pharmacist that Reduced Nurse Burden</td>
<td>6.6</td>
</tr>
<tr>
<td>Interventions Performed by Pharmacist that Reduced Case Management Burden</td>
<td>3.6</td>
</tr>
<tr>
<td>Interdisciplinary Consultation</td>
<td>5.8</td>
</tr>
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</table>
Transforming Safety: Improving the Daily Safety Huddle

With the right structures in place, engagement of participants, and a clear framework for accountability and follow-up daily safety briefings are an effective tool for escalating and resolving issues. In-person huddles improve reporting, raise situational awareness and promote real-time resolution.

Jacqueline Newton, MSN, RN, CPEN, NE-BC; Kathryn Merkeley, MHSA, RN, BSN; Lisbeth Fahey, MSN, RN; Linda Talley, MS, BSN, RN, NE-BC, FAAN; Rahul K. Shah, MD, MBA
Background

Daily safety briefings for situational awareness and risk identification are a foundational tool for high reliability organizations. Children’s National initiated a Daily Check-In (DCI) phone call in 2011 as a structured report out of clinical and operations areas, facilitated by the administrator on call, for the purpose of escalating risks and resolving safety issues. The DCI call was effective for reporting issues, but lacked accountability and closed-loop follow up on issue resolution. DCI Participants did not agree that the call format promoted real-time resolution of issues or dialogue among key stakeholders. To improve the effectiveness of the DCI and promote real-time problem solving, the call was transitioned to an in-person format in November 2019.

Objectives

Increase the percent of respondents who agree that “the Daily Check-In is effective in resolving issues in real-time” from a baseline of 69% to greater than 85%.

Methods

To improve the effectiveness of the DCI, the Nursing and Patient Safety teams:
-Benchmarked best practices and queried children’s hospitals
-Performed site visits to organizations in-person daily safety briefings.
-Analyzed the current state through surveys and feedback.

Gaps were identified in accountability, timely issue resolution, and closed-loop communication. The framework for the in-person huddle included: addition of a co-facilitator, a revised roll call, structured reporting template, a visual display for key information, and an outstanding issues list with assigned accountability and deadline for feedback (Figure 1). Simulation was used to train facilitators and participants prior to go-live.

Results

The percent of participants who agree that the Daily Check In is effective in resolving issues in real time increased from 69% to over 90%.

“The new DCI has really changed our safety culture. I appreciate the transparency, collaboration and open communication. I finally feel like everyone is on the same page and committed to safety being a top priority.”

“Really helping me resolve issues on the unit without numerous phone calls, emails. I like the new approach to DCI!”

Conclusions

With the right structures in place, engagement of participants, and a clear framework for accountability and follow up daily safety briefings are an effective tool for escalating and resolving issues. In-person huddles improve reporting, raise situational awareness, and promote real-time resolution.

Acknowledgements: Neil Bhattarai, CPHQ; Michael Shaw
Honorable Mention

Examination of a Pediatric Health System’s Health Literacy Environment

Sasha Smith, MPH; Tesa White; Desiree de la Torre, MPH, MBA; Wayne Neal, MAT, RN-BC; Tonya V. Kinlow, MPA

Communication in a health care setting is one of the most important tools we have for providing great patient care, improving satisfaction and addressing health equity.
Health literacy as defined by U.S. Department of Health and Human Services is “the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions” and is essential to promote health outcomes and communities.1 National data estimates that 30% of people have low health literacy and would have difficulty with common health tasks, such as following directions on prescription drug labels, understanding discharge instructions or adhering to a childhood immunization schedule. If low health literacy is recognized as a concern and providers are not clear, adhering to a childhood immunization schedule poses more of a safety risk for a person in caring for themselves and others.2 In our journey to becoming a health literate hospital, a multidisciplinary advisory committee composed of Children’s National’s employees was formed to analyze our current health literacy practices and make recommendations on how to better communicate with our patients and families.

**Objectives**

- **Engage** hospital leadership to make health literacy integral to its mission, structure, and operations
- **Assess** hospital employees on their knowledge, behaviors and health literacy practices
- **Identify** systems and policy approaches to address health literacy

**Results**

- The focus groups were conducted with Children’s National’s professional staff from a variety of clinical practices, who are responsible for educating and communicating health information with their patients and their families. Each focus group was conducted via Zoom video conference and lasted 60 minutes. There were two researchers present in each focus group, one focus group moderator, Wayne Neal, MAT, RN-BC, and one note-taker, Sasha Smith, MPH.
- The three focus groups that were conducted with Children’s National’s professional staff who were recruited via The Bear Report and a one-on-one focus group meeting were conducted with the focus group leader, Tonya V. Kinlow, RN, BC, and one note-taker, Sasha Smith, MPH.
- In late April and early May 2020, four interviews with employees were conducted. Based on input from the working group, employees with an interest in health literacy were identified to participate in the interviews. Interviews included clinical employees (inpatient and outpatient) and parent navigators. The interviews provided the opportunity for employees to provide their perspective on the importance of health literacy, challenges and barriers that care providers encounter when communicating with patients and families, and standardization and health literacy practices across the system, consequences witnessed as a result of poor understanding of health information, and recommendations and resources needed to improve health literacy practices.

**Conclusion**

Based on our findings, we recommend using the “Ten Attributes of Health Literate Health Care Organizations” discussion paper created by participants of the IOM Roundtable on Health Literacy. This list of attributes is not an exhaustive list, but a synthesized body of knowledge and practices that is supported by health literacy science. These attributes will inform the next steps of our journey to becoming a health literate health care organization. We will work with employees across the organization to prioritize which attributes to address first before broadening our efforts. In addition, we plan to work with hospital leaders to increase accountability and health literacy standardization across the organization. Future research should consider observing or recording how employees are communicating about medication instructions, discharge information, follow-up appointments, etc. as an essential part of patient safety. Through this work, we can ensure that employees are providing great patient care and improving patient satisfaction.

**References**

Clinical Nurses Promote Safety in Oncology Patients by Reducing CLABSIs

Honorable Mention

Having clinical nurses engaged in interventions to reduce CLABSIs is imperative in promoting safety in hematology and stem cell transplant patients.

Laura Martin, MS, RN, OCN, BMTCN; Kimberly Groner, MS, RN, ANP BC, CCRC, NE BC; LaToya Forrester, MPH, CIC

MedStar Georgetown University Hospital
Clinical Nurses Promote Safety in Oncology Patients by Reducing CLABSIs

Laura Martin, MS, RN, OCN, BMTCN; Kimberly Groner, MS, RN, ANP-BC, CCRC, NE-BC; LaToya Forrester, MPH, CIC

Clinical Concern

Over a 13-month period (November 2016 to December 2017) there were nine central line associated bloodstream infections (CLABSIs) on the hematlogy and stem cell transplant unit at an academic medical center. The equates to a rate of 2.41 CLABSIs per 1000 patient days.

Goal

The purpose is to determine if nursing-focused interventions decrease the incidence of CLABSIs on an 18-bed hematlogy and stem cell transplant unit.

Learning Objectives

After reviewing this poster, the learner will
- Describe CLABSI risk factors pertinent to patients receiving chemotherapy and/or stem cell transplants
- Describe interventions that can be implemented to improve central line care and reduce CLABSIs
- Identify next steps that may be useful in other organizations working to reduce CLABSIs.

Introduction/Background

Oncology patients receiving chemotherapy and stem cell transplants are at an increased risk for infection due to their compromised immune systems. Factors that contribute to the risk of infection include receiving an allogeneic stem cell transplant, graft versus host disease prophylaxis, steroid use, prolonged neutropenia, parenteral nutrition and use of a central venous catheter. Many of these patients require prolonged use of central venous catheters for supportive care following transplant, putting them at risk for CLABSIs. CLABSIs can result in increased length of hospital stays, increased healthcare costs, and negative patient outcomes. The interdisciplinary team plays a vital role in preventing infections in this patient population. Nurses are the primary healthcare providers caring for central lines, so nursing interventions can have a great impact on CLABSI reduction.

Methods

A number of interventions occurred over a four-month period from August through December 2017. A unit based CLABSI reduction taskforce was formed to evaluate current practice and discuss methods for improvement. This taskforce included nursing leadership, staff nurses and infection preventionists.

- The taskforce discussed and researched best practices for central line maintenance to develop interventions for implementation.
- All staff nurses were re-educated on central line dressing changes and needle-free port changes. Staff were observed performing dressing changes and needle-free port changes to ensure proper technique was used.
- The unit implemented a requirement of two nurses to be present to observe central line dressing changes.
- Weekly audits were established to observe central line dressings and care, intravenous tubing, chlorhexidine patches and to identify patients at risk for compromised lines. Documentation was also audited to ensure that all interventions were being properly charted.
- The taskforce created central line care door signs to include when the dressing and tubing are due to be changed as well as when the line was last accessed for lab draws.
- Color-coded tubing change stickers were ordered to improve compliance with changing intravenous tubing at the appropriate interval.
- The staff on the unit received ongoing emails and posted reminders about the CLABSI reduction initiatives. These were also discussed during shift huddles and during annual nursing education classes.

Results

Since these interventions, there have been two CLABSIs (January 2018 to March 2020), for a rate of 0.30 CLABSIs per 1000 patient days. As a result of the success on the unit, a hospital-wide CLABSI reduction taskforce was formed to disseminate successes and best practice. Since its inception in January 2018, the hospital-wide CLABSI reduction taskforce has reviewed and discussed event reviews for every central line infection that occurs at MGUH. The group discusses any new evidence as well as lessons learned from the event reviews performed for each CLABSI that occurs. Based on this, the group makes recommendations to the nursing practice council for updates to the nursing policy on central line care. Updates are provided to the nursing practice council on an ongoing basis.

Discussion

Having clinical nurses engaged in interventions to reduce CLABSIs is imperative in promoting safety in hematology and stem cell transplant patients. It is important that clinicians are always conscious of the risk of infection associated with central lines, so continued education and conversations about central line care are essential.

References


Improving Turn-arround Times for Chest/Abdomen X-Rays in the PACU in an Academic Medical Center

Derek Perkins, MPH, RT; Amanda Valentine, MEng MS; Dr. Shelly McDonald-Pinkett, Howard University and Howard University Hospital

Studying communication response times is a contributing factor in reducing process waste in order to provide excellent patient care.
Improving Turn-around Times for Chest/Abdomen X-Rays in the PACU in an Academic Medical Center

Derek Perkins, MPH, RT²; Amanda Valentine¹ MEng MS; Dr. Shelly McDonald-Pinkett¹²;
¹Howard University, ²Howard University Hospital

Background

Howard University Hospital is focused on improving how care is delivered to our patients. Our goal in our Lean Six Sigma process improvement journey to follow the Institute for Healthcare improvement (IHI) Triple Aim which is to provide a better patient experience, reducing per capita cost, and to ensure better health outcomes within our patient population.

Problem Statement (Gap Analysis)

In one prominent case, an x-ray report took longer than the average TAT and as a result it delayed a patient being discharged to home. The hospital wanted to make sure that all PACU x-rays are read in a timely manner so patient care will not be jeopardized.

Goals & Targets

✓ The goal is to ensure that there is a completed loop in communication about patient x-rays.
✓ The main process goal is to always go from completion of x-ray to results being reported back to the PACU (TAT) in 45 minutes or less.

Current Conditions

<table>
<thead>
<tr>
<th>X-ray #</th>
<th>PAA rec. time and notified tech</th>
<th>Tech performs x-ray</th>
<th>Tech notifies RAD</th>
<th>RAD reads x-ray</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 min</td>
<td>14 min</td>
<td>6 min</td>
<td>32 min</td>
<td>53 min</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>7</td>
<td>3 min</td>
<td>17 min</td>
<td>3 min</td>
<td>7 min</td>
<td>30 min</td>
</tr>
</tbody>
</table>

Takt time = 1.14 min 12 min 2.85 min 14.29 min

Analysis

In order to find the gaps in the process, radiology collected data on the length of time it took to go from Chest and/or ABD x-ray to results being reported back to the PACU (Figure A).

Proposed Countermeasures

Start: PAA rec. time and notified tech
Stop: X-ray results in SC

Results

TAT for PACU Port Chest and ABD X-ray

<table>
<thead>
<tr>
<th>Date of X-ray</th>
<th>Number of X-rays</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/5/2019</td>
<td>53</td>
</tr>
<tr>
<td>2/13/2019</td>
<td>37</td>
</tr>
<tr>
<td>2/21/2019</td>
<td>36</td>
</tr>
<tr>
<td>2/21/2019</td>
<td>19</td>
</tr>
<tr>
<td>3/1/2019</td>
<td>14</td>
</tr>
<tr>
<td>3/1/2019</td>
<td>23</td>
</tr>
<tr>
<td>3/1/2019</td>
<td>30</td>
</tr>
</tbody>
</table>

Contact

Amanda Valentine
Howard University
Email: avalentine@huhosp.org

Sustainability Plan

In the future, the radiology team will study the response time for Operating Room cases. It would specifically focus on the time radiology is notified by the operating room that they have a case and the response time of the radiology technologists reporting to the Operating Room.
Are we Ready for Smart Rehabs? A Pilot of Amazon Echos in Acute Rehab

Ivy Benjenk, RN; Mona Faddah, M.Ed, SLP; Kelly Pratt, DPT; Kyla Kerstetter, DPT; Robert Henry, MIS

Smart speakers can feasibly be used in an acute rehabilitation unit. Patients may derive a sense of accomplishment from being able to use a new technology, especially during a time where they need to work hard to accomplish tasks.
Are we ready for Smart Rehabs?

A Pilot of Amazon Echos in Acute Rehab

**Background:**

- 24% of Americans own smart speakers.
- They use them to listen to music, set alarms, play games, and search the internet.
- Smart speakers are easy to set up, easy to use, and have great potential benefit for individuals with vision loss, functional limitations, and rehabilitation needs, like speech, cognition, memory, and exercise.

**Aim:**

- Initial: To determine if smart speakers can feasibly be used on an acute rehab unit.
- Long-term: To determine if smart speakers can be used to enhance functional outcomes and patient satisfaction.

---

**PLAN (Summer 2018)**

- 10 interviews with ARU patients about their perceptions of smart speakers.
  - 2/10 had smart speakers at home.
  - 6/10 were using personal smartphones/IPADs in the hospital.
  - 6/10 were interested in using smart speakers in the hospital.
- 2 focus groups in August 2018.
  - ARU patients were able to ask for songs, play games, set reminders, and ask questions.
  - Majority of patients felt that speakers would improve the rehab experience.

**ACT (Spring 2020)**

- In their first 10 months of use, the Echos have been used primarily for music.
  - Only 33% of staff have set reminders for patients, only 17% have set alarms, and only 8% have controlled the speakers with the IPads.
  - 50% of staff report that their discomfort with technology is a barrier to their use of the Echos with patients.
- In response, we had a training focused on setting reminders, alarms, and “routines” and hope to determine if these functions can be incorporated into life on the unit.

**DO (May 2019)**

- We disseminated 1 Amazon Echo for the rehab gym, 10 Amazon Dots in wall mounts for patient rooms, and 2 IPads to control the speakers. This required:
  - Creating 1 Amazon Alexa account with 11 devices;
  - Adding 11 devices to the WiFi network;
  - Setting up 11 Pandora accounts;
  - Finding a place to store devices;
  - Creating standard operating procedures (to store devices, delete data); and
  - Training ARU rehab and nursing staff and IT helpdesk staff.

**CHECK (March 2020)**

- In March 2020, we conducted follow-up surveys with ARU rehab staff. We found:
  - 50% have given speakers to 5 or more patients.
  - One staff member reports having given speakers to more than 20 patients.
  - Most speakers are given to patients with no prior experience with the device.
  - 83% feel that the speakers positively or very positively impact patient care.
  - 73% feel that the speakers can probably or definitely be an effective rehabilitation tool.

---

Percent of staff members that report encouraging patients to use the following skills:

- Music: 92%
- Meditation: 58%
- Reminders: 50%
- Alarms: 33%
- News: 33%
- Games: 8%
Improving MAK Barcode Scanning Compliance in an Urban Academic Medical Center

Brittany Banbury, MD; Amanda Valentine, MEng, MS; Diana Tegegn, PharmD, Howard University and Howard University Hospital

Barcode scanning for medication administration in the inpatient setting can be implemented as a part of reducing errors in medication administration.
Improving MAK Barcode Scanning Compliance in an Academic Medical Center

Brittany Banbury, MD1; Amanda Valentine2; MEng MS; Diana Tegegn, PharmD2
1Howard University, 2Howard University Hospital

Aim
To reduce the overall noncompliance to less than 2% of total charted by Dec 31 on all units.

Introduction
Medical errors are costly and responsible for tens of thousands of potentially preventable in-hospital deaths nationwide. Errors in medication administration are among the most common, harming at least 1.5 million people per year, according to the Institute of Medicine of the National Academies. To prevent or minimize the occurrence of medication administration errors, many US hospitals have instituted rigorous patient safety programs using health information technology and barcode scanning. This technology has been useful in streamlining patient identification, medication management, specimen collection, blood transfusion safety and inventory management. However, studies have shown that compliance with this new technology is not always 100%, reportedly due to lack of knowledge and understanding of the infrastructure, inadequate staff training and technologic problems. This study assesses the hospital wide compliance of MAK barcode scanning, to determine the causative factors and implement a plan to decrease the rate of non compliance and thereby increase patient safety in medication administration, and overall.

Project Strategy
Hospital-wide non-compliance with MAK barcode scanning was assessed and found to be 20%. Further data was analyzed to determine the most frequent cause of MAK override/barcode non compliance.

Actions Taken
Data from June 2018 – May 2019 was assessed to first determine the compliance rate with barcode scanning in the entire hospital with respect to medication administration, using the Soarian point of care software. Each time an override is performed, the nurse administrator completes the medication error report form to determine the reason for the override in the point of care software. Once the non compliance rate was established the reports for a medical surgical unit were reviewed to determine to most frequent cause for MAK override, based on data recorded in the software.

Results
405,469 orders in total were placed over the 12 month period. Of these orders, 84,319 had barcode overrides. This calculates to be a 20% non compliance rate with barcode scanning for medication administration. On medical-surgical ward 4E, 732 charts were reviewed in July, and 595 charts reviewed in November, with noncompliance rates on this unit alone of 4.4% and 2.6% respectively. In July reasons listed for override included: ‘medication has no barcode’, ‘medication was given during system downtime’, and ‘medication barcode is unreadable’. In November, the reasons included ‘barcode scanner is unavailable’, ‘patient has own medication pump’, ‘medication has no barcode’, ‘patient on isolation’. In July, of the 33 charts on 4E that had barcode overrides, 27 of those overrides were due to medication barcode being unreadable.

Conclusions
This study demonstrated that one of the main contributing factors of non compliance with barcode scanning in medication administration in our institution is an unreadable medication barcode. This represents a technological barrier to compliance with MAK barcode scanning for medication administration which was implemented as a patient safety strategy to decrease medication errors in our patient population. Our medication administration barcode override rate is 20% hospital-wide, found to be a result of unreadable barcodes. This technological problem could be secondary to multiple factors. In an effort to reduce MAK non compliance rate to 2% by December 31st we plan to identify areas where technological difficulty is causing MAK overrides, including developing a standardized criteria for a ‘readable’ barcode and advise printing staff to discard those that do not meet the necessary criteria; determining a fixable cause of the technological difficulty – trouble shooting printers, replacing ink cartridges, broken barcode scanners and require printing staff to alert engineering to make the necessary repairs to minimize ineffective printing. Only ‘readable’ barcodes to be placed on patients’ wristbands and in charts to streamline the scanning process.

Contact
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Email:
The best way to prevent and slow down transmission is being well informed about the COVID-19 virus, the disease it causes and how it spreads.
Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The best way to prevent and slow down transmission is being well informed about the COVID-19 virus, the disease it causes and how it spreads. The Centers for Medicare and Medicaid Services (CMS) recently issued guidelines that outlines criteria that could be used to prepare long-term care facilities on safety protocols.

BridgePoint Healthcare has 2 locations. The Capitol Hill location had 6 cases of COVID-19 (transferred form other facilities) and the National Harbor location had 0 cases. 100% negative COVID-19 testing for SNF staff over 2 months. There were 0 patient conversions to COVID-19 at either location. Employee morale remained high, and the organization experienced no turnover.

Successful Management of COVID-19 at BridgePoint Healthcare LTAC (Long-term Acute Care) & SNF (Skilled Nursing Facility)
Veronica Parham-Dudley MSN, RN CPM *Savetria N. Bonaparte MSN-Ed, RN* Sheryl P. Williams RN, IP

Background
Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The best way to prevent and slow down transmission is being well informed about the COVID-19 virus, the disease it causes and how it spreads. The Centers for Medicare and Medicaid Services (CMS) recently issued guidelines that outlines criteria that could be used to prepare long-term care facilities on safety protocols.

Methods
- BridgePoint Healthcare increased its amount of personal protective equipment (PPE) in anticipation for preparation for the pandemic.
- In addition, BridgePoint increased infection control awareness for the entire organization.
- Over the course of two months, BridgePoint conducted weekly testing of their skilled-nursing staff.
- High-risk employees were vetted and allowed to work from home. BridgePoint established a no-visitor policy except in extreme circumstances.

Objective
- Establish Safety Protocols for COVID-19 at BridgePoint Healthcare

Results
- All positive cases were transferred from other facilities.
- 0 COVID-19 conversion cases.
- 0 COVID-19 cases at National Harbor.
- 6 COVID-19 cases at Capitol Hill.
- Total number of patients: 250

Conclusions
- BridgePoint Healthcare has 2 locations. The Capitol Hill location had 6 cases of COVID-19 (transferred form other facilities) and the National Harbor location had 0 cases. 100% negative COVID-19 testing for SNF staff over 2 months. There were 0 patient conversions to COVID-19 at either location. Employee morale remained high, and the organization experienced no turnover.

References
DCHA is the unifying voice for hospitals and health systems in the District of Columbia and works to advance health policy to strengthen the District’s world-class health care system to ensure that it is equitable and accessible to all.