PREVENTION OF PHLEBITIS IN WARD C8

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- ☑ SAFETY
- ☐ PRODUCTIVITY
- ☑ PATIENT EXPERIENCE
- ☐ QUALITY
- ☐ VALUE

Define Problem/Set Aim

Opportunity for Improvement

Between August 2018 to June 2019, there were 3 reported incidents of phlebitis in NTFGH and 1 incident of phlebitis is accounted for in ward C8 since the opening of the ward on 2nd April 2019. Patient's knowledge deficit in intravenous cannula care led to complaints of pain, site infection leading to increased treatment costs and caused unnecessary concern for the patient's family members.

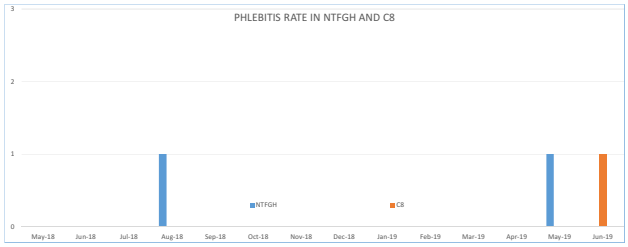
Aim

To increase patient and family knowledge in intravenous cannula care and to achieve a zero phlebitis rate in ward C8.

Establish Measures

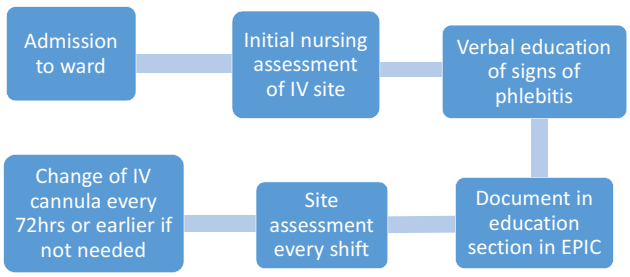
Outcome measure:

The number of incidences of phlebitis reported for patients admitted, one case was identified for Ward C8.



Analyse Problem

Process map



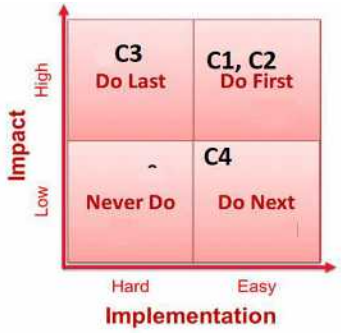
Probable root cause

The project team identified insufficient communication and knowledge in particular as the root cause of increased risk of IVC complications from the time of admission to discharge. Correspondingly, the project team identified possible interventions as countermeasures to the lack of communication and knowledge identified.

Select Changes

What are the probable solutions?

Project team used impact-implementation matrix to prioritize change ideas for PDSA cycle.



Primary driver	Change ideas	
Poor communication and knowledge	C1	Brochure on IVC care
	C2	Patient-family and staff education
	C3	Extra IVC site check during shift
	C4	Regular quality checks and reinforcement on education

Test & Implement Changes

CYCLE	PLAN	DO	STUDY	ACT
1	To test the understanding of IVC use in ward C8 patients with IVC cannula on admission	To do pre test of IVC knowledge followed by post test after distribution of brochure.	Phlebitis rate remains at zero. Proper communication and education are key in preventing incidences of IVC complications.	The project team decided to adopt the brochure idea and incorporate it in all patient admissions.

Spread Change/Learning Points

1. Daily reminder and reinforcement of brochure distribution to be done during daily role call in ward C8.
2. Ward staff and nurse clinician were receptive in implementing the idea of brochure distribution to all new patients with IVC.
3. Plan can be improved by asking patient to provide a read back of their understanding of the brochure.

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