Quality Perspectives

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Order your PICC early

Discharge Planning begins at Admission

As we all work to provide more efficient care, the PICC team has analyzed their data and found that a substantial number of PICC's are requested late in the day, after hours, and on patients without valid indications. Placing a catheter into the central circulation is not something that should be taken lightly; the sequelae of a central line associated blood stream infection can be devastating.

There are a few keys to being sure PICC's are used appropriately.

1- Identify candidates for PICC's early. Patients requiring long term antibiotics, home antibiotics, or TPN, and patients with sepsis and other complex conditions should be PICC'd earlier rather than later.

2- Use IV experts for peripheral IV placement. If an iv is only needed for a short time, a peripheral placed by a specialist can eliminate the need to call in the PICC team after hours.

3- Discuss the PICC with the patient prior to ordering. Hard to believe but several patients have refused once the PICC nurse arrived!

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"Crazy" Expensive!

Delirium costs US $50 billion per year

Hospitalized patients are thrown into a new environment full of beeps and rings and machines, stuck with tubes and needles, asked the same questions over and over again, waken at night to be sure they are sleeping well and all too often they get confused. Once confused, they then get a new set of blood tests, strapped to a table for a MRI that invariably shows nothing new and shot full of sedatives. Then comes the nosocomial UTI, the bed sore, aspiration pneumonia and transfer to the nursing home, never to be the same again.

Wouldn't it be better to prevent delirium? Here's a bunch of simple measures from the National Institute for Health and Clinical Excellence that are evidence-based, easy to perform and actually work:

Avoid Foley catheters; *Orient your patient frequently*; ensure adequate hydration; **assess for hypoxia**; *encourage mobility- sit up for meals and walk the halls*; **discontinue unnecessary medications**; *ensure adequate nutrition*; **and promote good sleep by minimizing disturbances**.

Speaking of Medications…

Are you sure your patient needs all 15???

An 88-year-old male was recently admitted to the hospital from a local nursing home for treatment of a urinary tract infection with possible sepsis. The patient had dementia and was fed by a G-tube; he was bedbound and was chronically confused. He had diabetes, hypertension and an old CVA and MI. His list of medications from the nursing home included lisinopril, metformin, Insulin, metoprolol, Lexapro, Lipitor, Aricept, and Namenda along with several vitamin supplements.

While one can see the value of treating the blood pressure and blood sugar, is there any benefit to treating his dementia or high cholesterol at this stage in his disease process? Is Lexapro still needed? Most likely these medications were started years ago when the patient had a better functional status but "clinical intertia" led them to be continued way past their usefulness and effectiveness, not to mention the cost to the patient, family or insurer and potential side effects and interactions with other medications.

Next time you reconcile your patient's medications, look at each medication on the list with a critical eye. What is the benefit? What are the risks? Are there medications that can be tapered or stopped? Many times discontinuing a medication is the best thing you can do for a patient.