Creating a Sea of Safety: An Initiative to Reduce Hospital Acquired Conditions in a Children’s Hospital

Elaine Henry, MSN, RNC-NIC, QNS

Unified Quality Improvement Symposium
February 5, 2020
Maynard Children’s Hospital – 198 beds
- > 6000 admissions/year
- Neonatal and pediatric patients

Susceptible to hospital acquired conditions (HAC)

Pediatric revamping of safety culture needed

Realignment of resources and teams

Back to the basics to improve compliance and results
Collaborative Team Members

Project Leader(s) and Discipline:
Elaine Henry, MSN, RNC-NIC – QNS-III, Women’s and Children’s
John Kohler, MD, MBA, FAAP – Medical Director for Quality, Women’s and Children’s

Team Member Name(s) and Discipline:
Kim Crickmore, PhD, RN, FABC – Vice President, Women’s and Children’s
Tara Stroud, MSN, RN, NNP-BC – Administrator, Children’s Hospital
Ryan Moore, MD, FAAP – Co-Medical Director, Children’s Hospital
Matt Ledoux, MD – Co-Medical Director, Children’s Hospital
Jason Higginson, MD, MA, FAAP – Pediatrician-in-Chief, Children’s Hospital
AIM Statement

Our aim was to decrease HAC to zero events per month in MCH patients within 6 months of project start in April 2018 by engaging multidisciplinary partners at all levels to change culture.
How Will We Know This Change Is An Improvement?

**Outcome Measures**
- Number of hospital acquired conditions
- Financial impact of preventable conditions

**Process Measures**
- Overall bundle compliance in each unit
- Hand hygiene compliance across units and disciplines
- Safety event & safety catch reporting
## Baseline Data

<table>
<thead>
<tr>
<th></th>
<th>FY 16</th>
<th>FY 17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HACs</strong></td>
<td>77</td>
<td>64</td>
</tr>
<tr>
<td><strong>Bundle Compliance</strong></td>
<td>89.80%</td>
<td>83.4%</td>
</tr>
<tr>
<td><strong>Hand hygiene</strong></td>
<td>92.0%</td>
<td>95.8%</td>
</tr>
<tr>
<td><strong>CLABSI</strong></td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td><strong>CLABSI rate</strong></td>
<td>n/a</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>UE</strong></td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td><strong>UE rate</strong></td>
<td>0.95</td>
<td>1.15</td>
</tr>
<tr>
<td><strong>SI events</strong></td>
<td>503</td>
<td>552</td>
</tr>
<tr>
<td><strong>Safety catches</strong></td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**HACs:**
- UE
- CLABSI
- CAUTI
- HAPU
- VAP/VAE
Improvement Strategies

January 2018
Medical Director for Quality and Quality Nurse Specialist

March 2018
Repurpose/realign Children’s Hospital Quality Committee into Children’s Hospital Quality Group

April 2018
Multi-disciplinary, multi-unit teams to focus on each HAC

May 2018
Sea of Safety branding campaign begins

June 2018
Quality Leader rounding

August 2018
Formal kickoff for Sea of Safety
Structure & Team Interventions

Sea of Safety

Children’s Clinical Service Executive Committee

Children’s Hospital Quality Group

CLABSI
- Unit level audits on bundle compliance
- Umbilical care bundle
- Standardize PICC line care

ADE
- Monthly meeting to review SIs
- Insulin events focus

UE
- Collaboration with respiratory
- Data transparency
- High risk airway cards

Safety
- Safety coaches & hand hygiene audits
- Safety event reporting

CLABSI

ADE

UE

Safety

CLABSI CAUTI HAPU VAP SSI UE ADE

READMISSIONS

DART
Outcomes
Outcomes

Total POTENTIAL savings to the system: $2,073,266
Challenges Encountered in QI Process

- Hospital & system improvements occurring at same time
- Promoting staff engagement
Lessons Learned Through QI Efforts

- Leadership buy-in is crucial
- Multi-unit, multi-disciplinary teams are meaningful
- Changing the culture to speak up for safety
- Involve “on the ground” team members
Next Steps

- Sustain the culture
- Modify or refocus the HAC teams
- Division specific outcomes/ opportunities
- Engage families in the work
Questions?

Elaine Henry
252-847-2079
elaine.henry@vidanthealth.com