

Unified Quality Improvement Symposium March 31, 2017

Background / Introduction

- The unplanned extubation (UE) rate is an important quality indicator. A benchmark UE of 0.1 to 2.6 per 100 device days is documented in the literature.
- UE may lead to significant cardiovascular or respiratory compromise.
- The population affected: all intubated infants in the NICU
- VMC NICU ventilator days in fiscal year 2012 averaged over 200 ventilator days per month. In 2012, VMC rate of UE was more than 2 times the benchmark VMC had set of <1/100 device days.

Collaborative Team Members

- Sharon Buckwald, physician
- Martha Naylor, physician
- Ryan Moore, physician
- Jason Higginson, physician
- Debora Williams, data analyst/respiratory
- Rhonda Creech, RN, NICU Nurse Manager
- Neva Pyles-Peaden, RRT
- April Russell, RRT
- Jennie Martin, RN

AIM Statement

A quality improvement project was undertaken in February 2012 to decrease unplanned extubations in our NICU with a goal to be below the national benchmark of 1/100 device days.

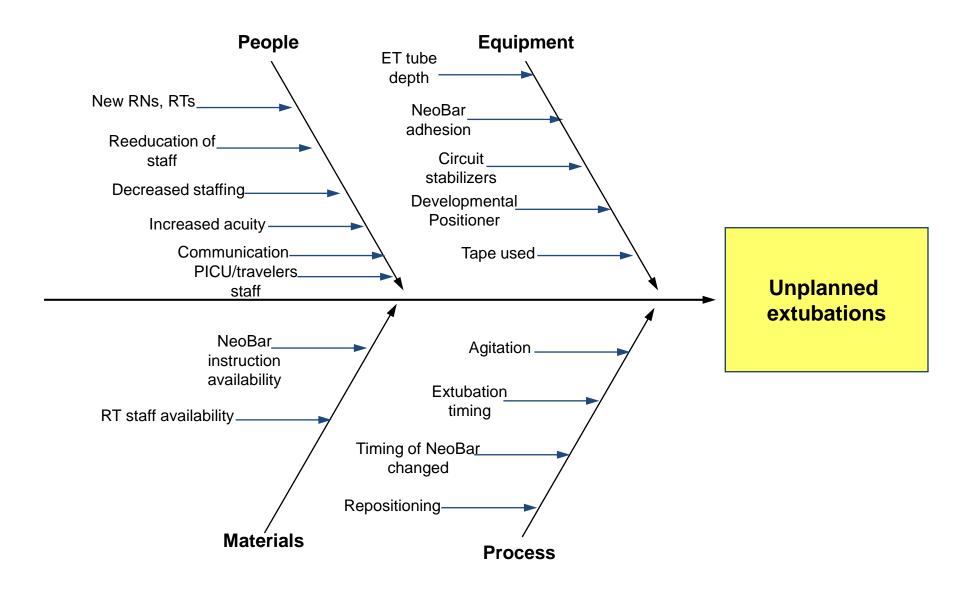
Measures

- Unplanned extubations per device day
- NICU device days
- NICU rate per 100 device days
- Number of reintubations after unplanned extubations
- Number of planned extubations
- Number of reintubations after planned extubations

Baseline Data

NICU Respiratory Data	Fiscal year 2012
Intubations	344
Unplanned Extubations	70
# UE reintubated within 48 hours	42
UE Rate	2.83
Planned Extubations	351
# of planned extubations reintubated within 48 hours	42
Reintubation rate	20.98

Causes of Unplanned Extubations

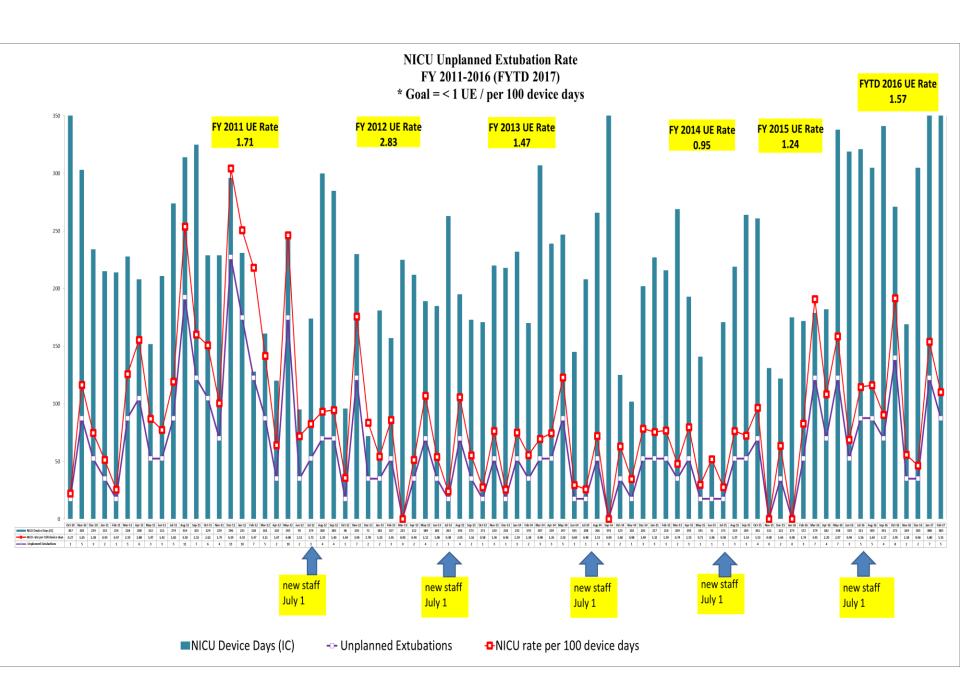


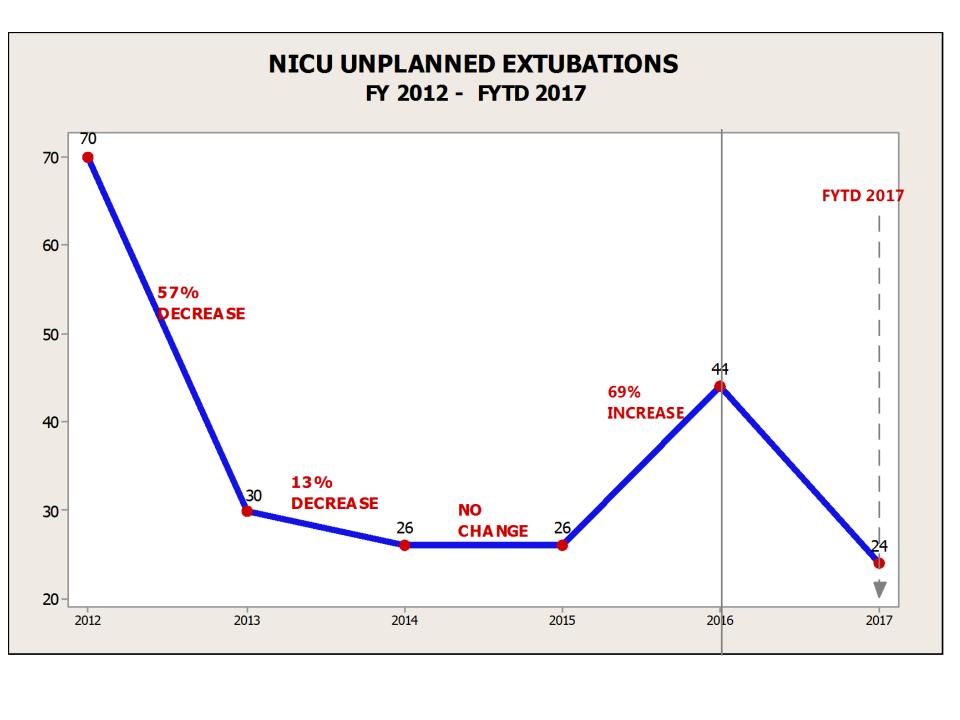
Improvement Strategies Employed

- Staff re-education on NeoBar®
- ET tube/NeoBar® rounds
- White board updated
- Implementing 2 staff members to reposition intubated patients
- More frequent x-rays
- Creation of a database for UE
- 2nd in-service on NeoBar®
- Monitoring ET tube position in growing ELBWs
- Determining proper tape to use on ET tubes
- Re-education on developmental positioners

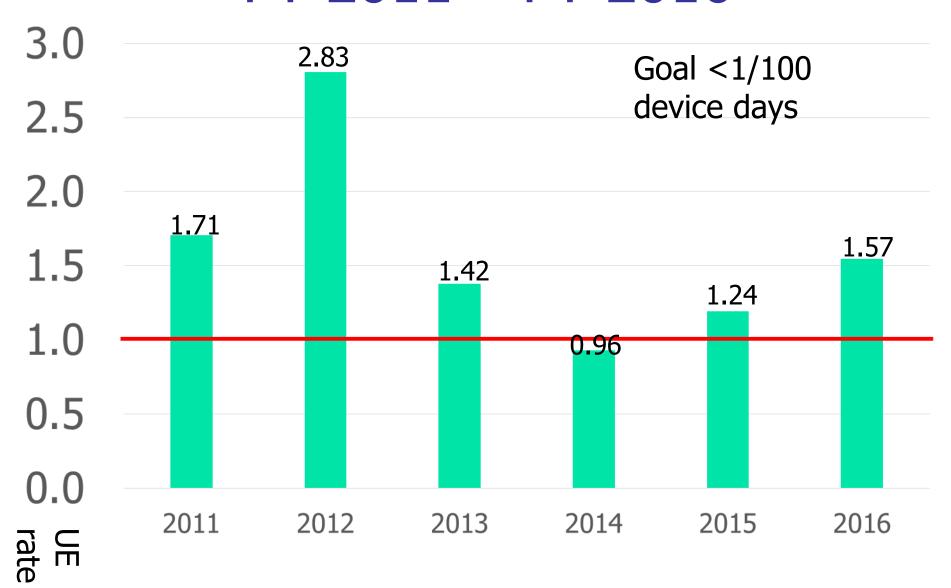
NeoBar®



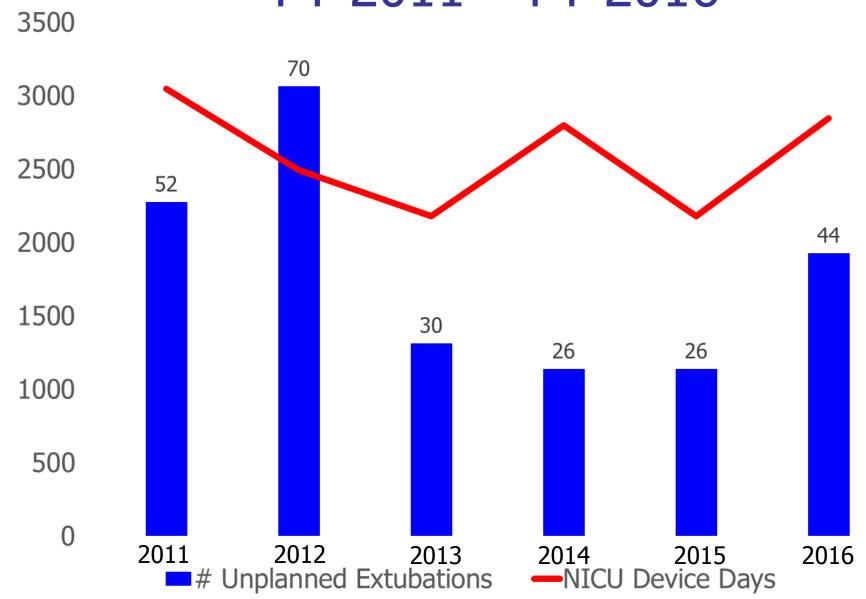




NICU Unplanned Extubation Rates FY 2011 – FY 2016



NICU Ventilator Device Days FY 2011 – FY 2016



Challenges Encountered in QI Process

- New staff (RNs and RTs)
 - Ongoing education
- Tape discontinued
 - Discussion with other NICUs to determine what tape to try
- Increase in number of unplanned extubation
 - Determine reasons and possible solutions
 - Respiratory manager met with PICU/NICU Medical Directors

Lessons Learned Through QI Efforts

- Ongoing education
- Continued analysis/discussion
- Input from all disciplines
- Team meetings

Next Steps

- Continued ongoing education for repositioning/procedures with RNs and RTs
- All unplanned extubations must be reported to Respiratory Shift supervisor
- Include in database if infant secured in ROO positioner
- Consider new ET tube fixation devices
- Consider weekly chest x-ray for ET tube position

Acknowledgements

- Debora Williams
- NICU Nursing
- Respiratory Therapists
- TQA mentors

