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

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Unified Quality Improvement Symposium

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Background / Introduction

- 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

	FY 16	FY 17
HACs	77	64
Bundle Compliance	89.80%	83.4%
Hand hygiene	92.0%	95.8%
CLABSIs	18	7
CLABSI rate	n/a	1.4
UE	50	54
UE rate	0.95	1.15
SI events	503	552
Safety catches	n/a	n/a

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

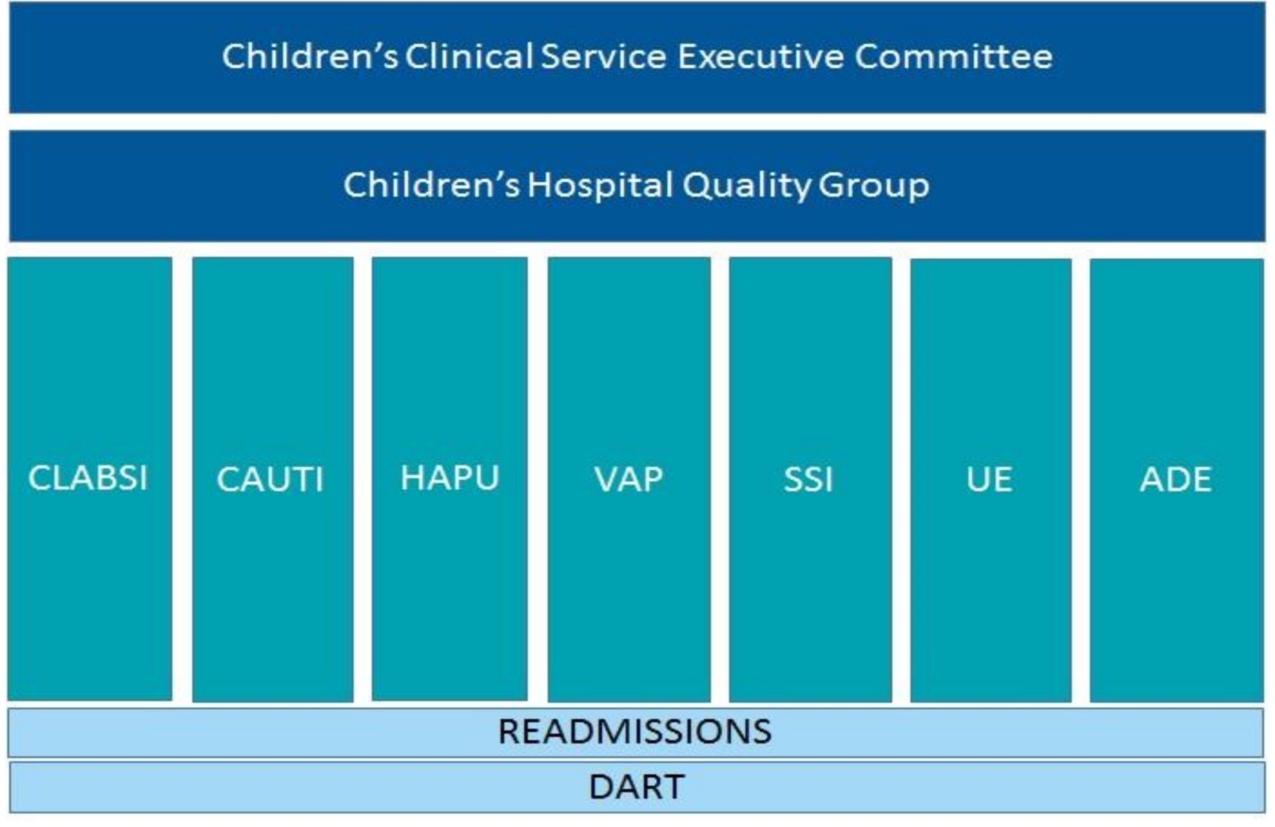
April 2018
Multi-disciplinary, multi-unit teams to focus on each HAC

May 2018
Sea of Safety branding campaign begins

June 2018
Quality Leader rounding

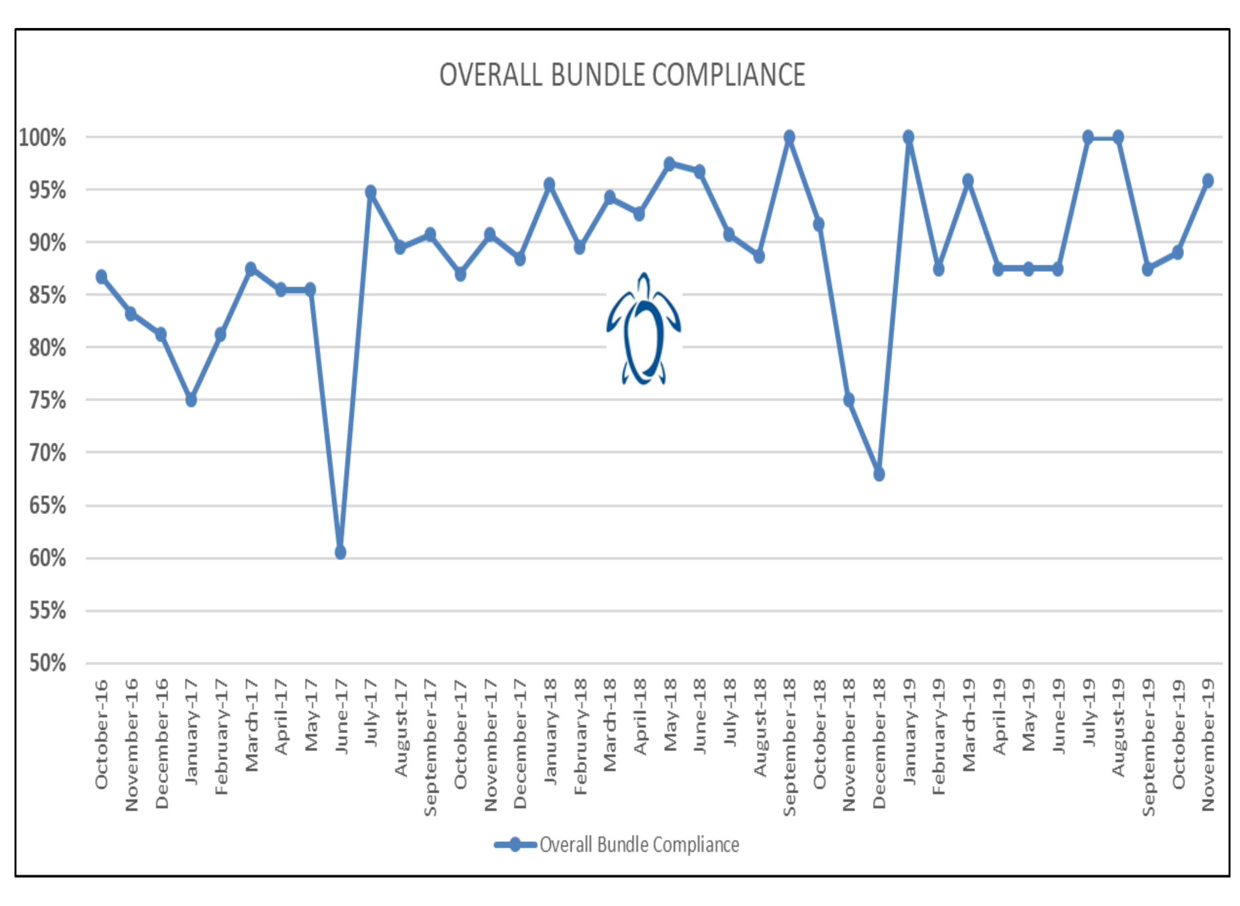
August 2018
Formal kickoff for Sea of Safety

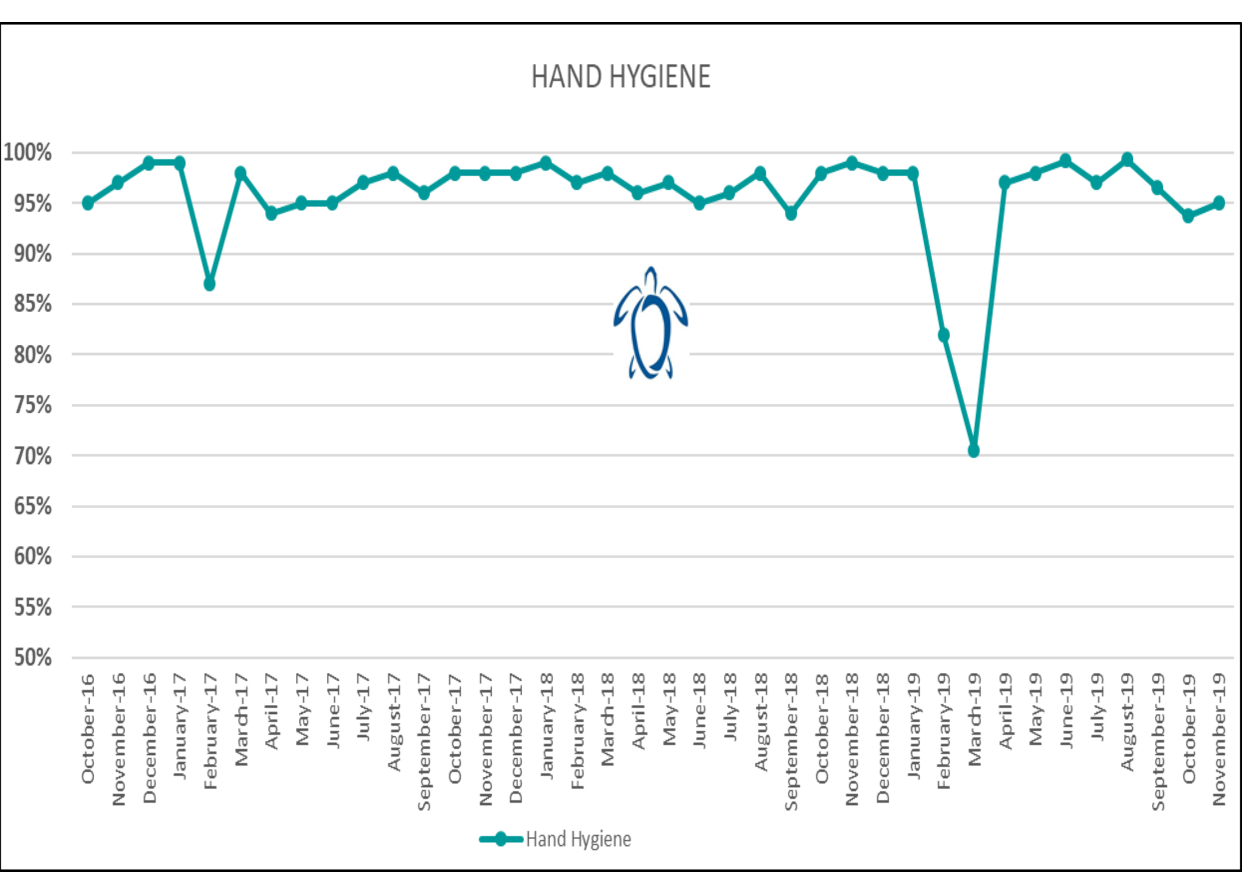
Structure & Team Interventions



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

Outcomes





Outcomes

TOTAL CH HAC

12
10
8
6
4
2
0

October-16, November-16, December-16, January-17, February-17, March-17, April-17, May-17, June-17, July-17, August-17, September-17, October-17, November-17, December-17, January-18, February-18, March-18, April-18, May-18, June-18, July-18, August-18, September-18, October-18, November-18, December-18, January-19, February-19, March-19, April-19, May-19, June-19, July-19, August-19, September-19, October-19, November-19

Sea of Safety

HAC reduction: 54

Total POTENTIAL savings to the system: **$2,073,266**

ENTERING THE
Sea of Safety

Sea of Safety

WASH YOUR HANDS

FOLLOW PROTOCOLS

LISTEN TO CONCERNS

SPEAK UP

TAKE CARE OF YOURSELF

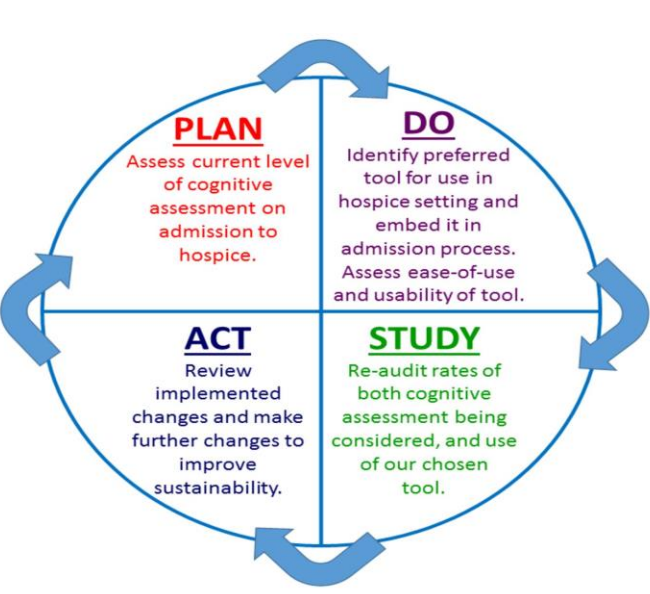
VIDANT HEALTH

PEDIATRIC PHARMACY

"SEA" WHAT 2 WEST IS DOING FOR CVL SAFETY

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?

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