Quality Reports

Zeroing in on zero harm: Quality and safety initiatives
Children's National Hospital

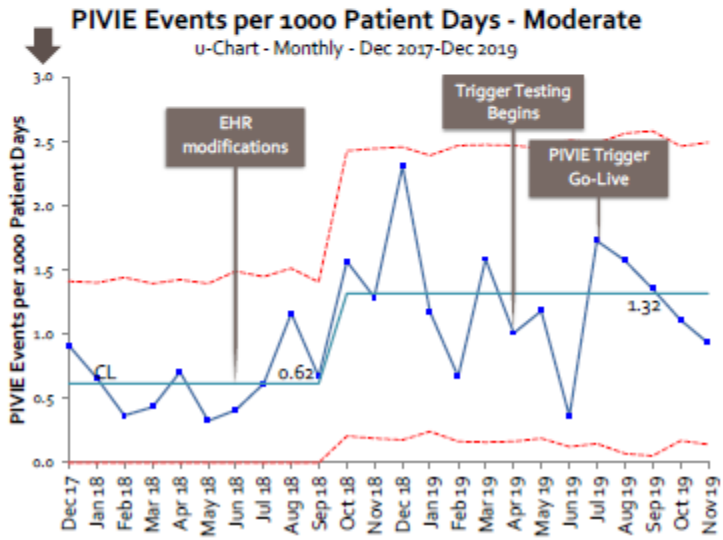
zero in on zero harm®

Improving Surveillance of PIVIE

Children's National Peripheral IV Infiltration and Extravasation (PIVIE) Prevention Team created an innovative surveillance system that effectively tracks our PIVIE events.

Peripheral IVs are short tubes that are inserted in a patient's vein, typically in the arm, and help healthcare providers administer fluids and medication. Sometimes, the IV may be inadvertently placed outside the vein causing fluids to be delivered in the tissue outside the vein causing a PIVIE. PIVIE can cause patient harm, especially in pediatric patients who possess smaller and weaker blood vessels, immature skin, or are constantly moving.[1] The PIVIE Prevention Team believed that events were underreported, impacting our ability to identify appropriate areas for improvement.

The team worked with information technology/Cerner to include PIVIE as a field in the electronic medical record. The teams also partnered with our Pediatric Triggers Program to add a daily automatic surveillance report. Cases were subsequently reviewed and reported as safety events. By combining multiple databases into one, the team increased its reporting twofold. Our understanding of PIVIE rates improved as the number of reported cases increased and led to appropriate quality improvement. These QI efforts have shown a decreasing trend for moderate events since July 2019.



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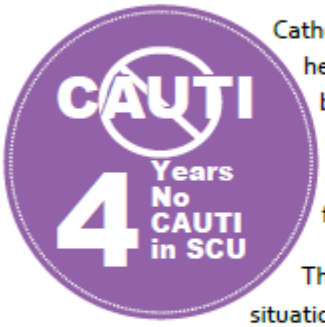
Surgical Care Unit Achieves 4 Year CAUTI-free Milestone

The Surgical Care Unit (SCU) reached a critical milestone. From October 2015 through 2019, the SCU had zero cases of catheter-associated urinary tract infections (CAUTI), achieving the rare distinction of being "CAUTI-free" for four years.



Catheter-associated urinary tract infections are the most common type of healthcare-associated infection.[1] A urinary catheter is a tube inserted into a bladder through the urethra to drain urine. Patients unable to void may be required to be catheterized. Between 15-25% of hospitalized patients receive urinary catheters during hospital stay. The most contributory risk factor for developing a CAUTI is prolonged use of urinary catheter.

The SCU theme is "If you don't need it, take it out." SCU nurses practice situational awareness huddles twice a day and have ongoing engagement with the clinical teams. SCU utilizes a tool, a Kamishibai card, popularly known as K-Cards. Unit-based educators use these cards to engage staff in conversation about specific care processes and determine compliance with care guidelines.

SCU conducted quality improvement initiatives that reduced CAUTI rates as well as rates for other hospital acquired conditions, such as catheter-associated bloodstream infections and peripheral IV infiltrates. SCU shares the success of its methods to spread these best practices.

Reducing Pressure Injuries

Pressure injuries are localized damage to skin or underlying soft tissue over a boney prominence or under a medical device. Pressure injuries can cause increased length of stay and poor patient outcomes. Children's National has a dedicated team, the Skin Team, which works on reducing hospital-acquired pressure injuries.

The Skin Team at is comprised of over 70 registered nurses and patient care technicians who collect pressure injury prevalence data monthly on all 10 inpatient units. Data are submitted to National Database of Nursing Quality Indicators (NDNQI). Prevalence data allow the hospital leaders to understand 1) how many patients have hospital-acquired pressure injuries at a set point in time each month and 2) how we compare to other hospitals.

Throughout 2019, the Team focused on implementing standardized education and PI prevention strategies, especially for medical device-related pressure injury rates.

Between 2018 and 2019, the device-related pressure injury prevalence rates decreased 29%.

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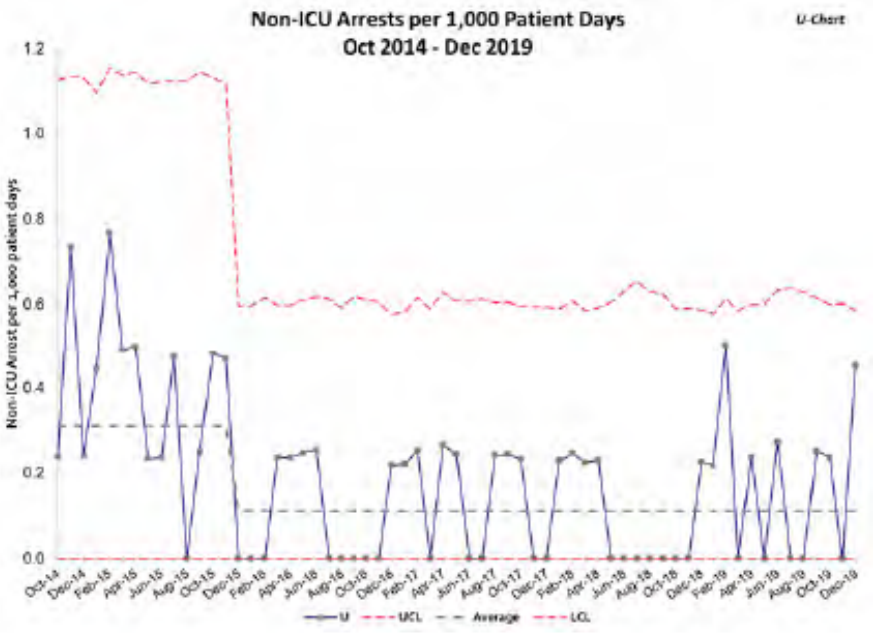
Decreasing Codes Outside the ICU's

The Late Rescue Collaborative (LRC) continues to test new strategies to increase situational awareness, appreciation for signs of deterioration, and escalation of care. Over the past four years, the interdisciplinary team supported efforts to streamline escalation protocols, build Rapid Response Team (RRT) capacity, and implement interdepartmental clinical event reviews. Results include a sustained reduction of arrests outside the ICU by over 50% since 2016. In the last fiscal year, improvements in days between arrests outside the ICU reached a multiyear high of 219 days, and total late rescue events decreased year over year by 22%.

Moving forward, the collaborative will roll out the Safety Dashboard and begin Evening Safety Huddles in February 2020. Dr. Lisa Rickey, a current third year resident, will lead efforts to test this intervention. "Our front-line clinical providers will utilize this dashboard to improve inter-professional communication and situational awareness in a novel way on our acute care floors," said Dr. Rickey. "We aim to use these tools to identify patients at greatest risk for decompensation, to triage resources for their care, and to reduce early morning unplanned ICU transfers."

The LRC encourages clinical teams to leverage the Safety Dashboard and welcomes the opportunity to collaborate on efforts to improve our detection and escalation of care for at-risk patients.



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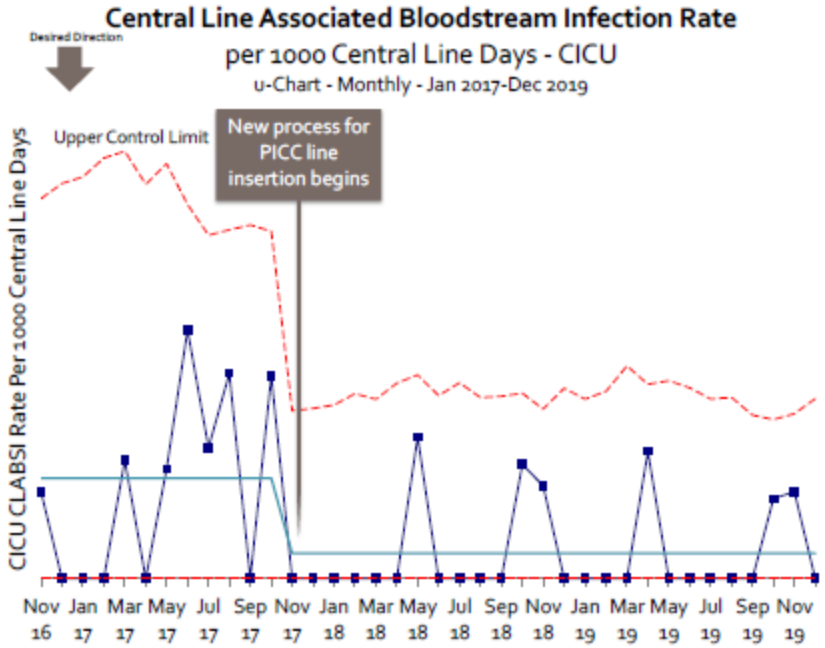
Reducing Hospital Acquired Conditions

CLABSI Reduction in the Intensive Care Units

PICU Goes One Year without a CLABSI, and CICU sees a 75% Reduction

Using innovative safety procedures, the multidisciplinary Cardiac Intensive Care Unit (CICU) and the Pediatric Intensive Care Unit (PICU) significantly reduced instances of central line-associated bloodstream infections (CLABSI).

A central line, also known as a central venous catheter, is a catheter that doctors often place in a large vein in the neck, chest or groin to give medications and fluids or to collect blood for medical tests. They are typically used in intensive care or hematology/oncology patients. Central lines can remain in place for weeks or months and can cause infections known as central line-associated bloodstream infections. Healthcare providers must follow a strict protocol when inserting or accessing the line.[1]



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Key projects implemented at Children's National to enhance patient care and reduce harm, including:

- Safety in Numbers: Recognizing barriers to reporting safety events, Children's National embarked upon a three-year corporate goal to double the number of safety event reports, ultimately leading to reduction of preventable harm. By promoting staff accountability and using incentives to drive reporting, incident reports more than doubled in a three-year time frame.
- Moving from Disjointed Spreadsheets to a Real-Time Data Management System –Tracking hospital-acquired conditions (HACs) requires robust data capabilities, The team recognized opportunities to improve the management of HAC data, leading to the finding that increased real-time awareness of harm events while utilizing existing infrastructure can accelerate harm reduction.
- Improving the Surgical Experience for Children with Autism. Staff at Children's National found that many patients with autism entering the operating room needed special support to make it through pre-op, complicating their path toward surgery and causing frustration for patients, families and the care team. The team solved this challenge by creating a system to identify patients before they arrived for surgery, which allowed staff to create a safe passage plan for each patient and to achieve better care coordination with all care team members. Titled "Help Me Keep Calm," the hospital's program provides a more peaceful and individualized experience for both the patient and his or her family.
- IMPACT Session: Enhancing Psychological Safety to Improve the Safety Climate. Psychological safety around event reporting is a crucial element of safety culture and the ability to voice concerns without reprisal leads to the ideal safe environment.