A Culture of Safety in the Neonatal ICU: An Improvement Story

Kathleen Marble MSN, RNC-NIC
Sparrow Hospital

Potentially Better Practices

Reduce BSI

Reduce Transmission

- Hand Hygiene
- Environmental Cleaning
- Staff & Family Education

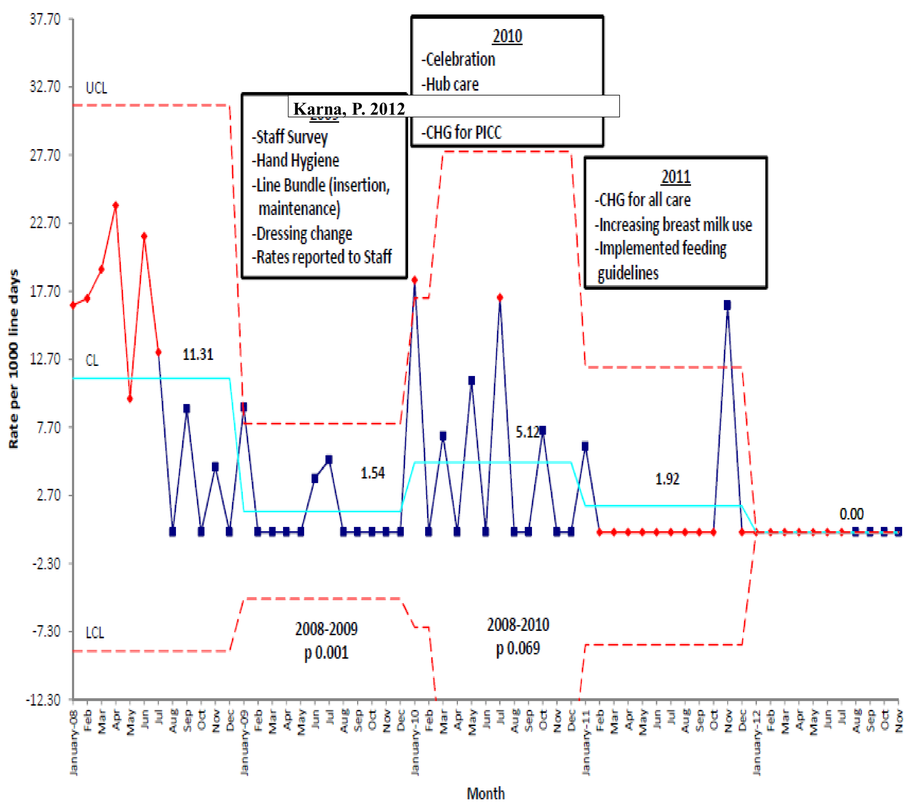
Reduce Catheter Contamination

- Insertion Bundle
- Maintenance Bundle
- Timely Removal

Promote Culture of Safety

- Team Training & Communication
- Monitor & Feedback
- Root Cause Analysis

Sparrow NICU CLABSI Analysis based on 12 month intervals



Karna, P. 2012

Creating a Culture of Safety

- ❑ Educate staff/all disciplines
- ❑ Safety assessment of the Neonatal ICU
- ❑ Assemble safety team
- ❑ Include Executive partnership & engagement in the project
- ❑ Learn from a defect tool
- ❑ Teamwork & communication tools
- ❑ Checklist
- ❑ Consistency in practice-monitor

Team Engagement

1. Multidisciplinary involvement
2. Engagement on Rounds: Nurse/Physician
3. Personal accountability
4. Problem solving
5. Ownership
6. Staff looking for opportunities
7. Looking for system failures

REFERENCES

- www.ahrq.gov/cusptoolkit/

MAGNET RECOGNITION
AMERICAN NURSES CREDENTIALING CENTER

Sparrow