

Drivers of Change Examples

Birth of an SBU: Improving Micro-Premature Infant Care

Children's Hospital of Illinois | Peoria, Illinois | USA | NICQ Next2

Drivers of Change: Our team, in conjunction with a panel of parents of <27 week infants cared for in our NICU, identified 7 areas of practice that we felt would have the greatest impact on improving the outcomes of the micro-premature infants treated in our unit. These drivers of change are: Consistency of Care, the Golden Hour, Family as Partners, Neurological Outcomes, Reducing Chronic Lung Disease, Improving Nutrition, and Infection Prevention.

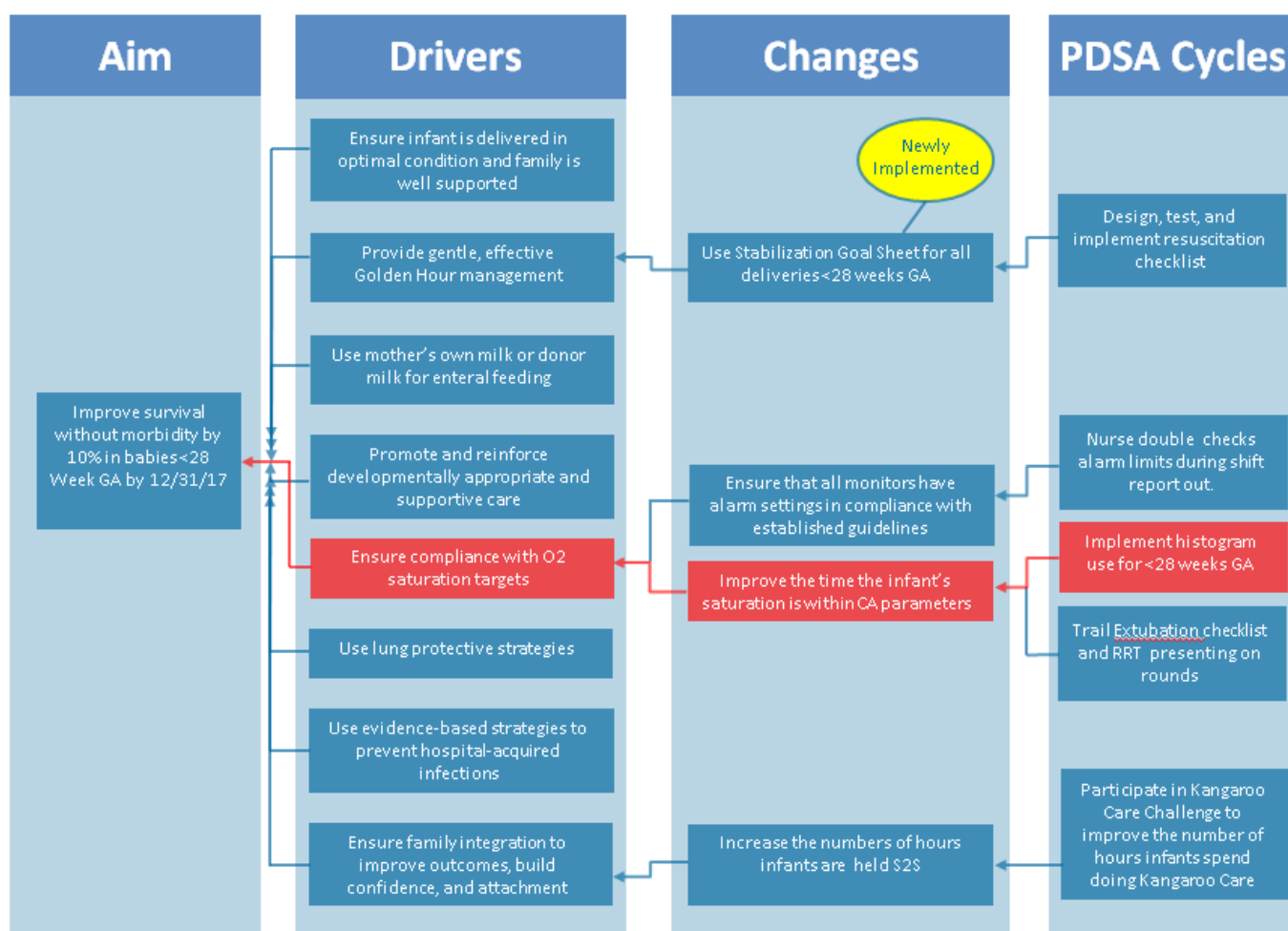
Big Changes for Small Babies

Miami Valley Hospital, Dayton, Ohio, USA

Tracy Morrison BSN, MSQA,

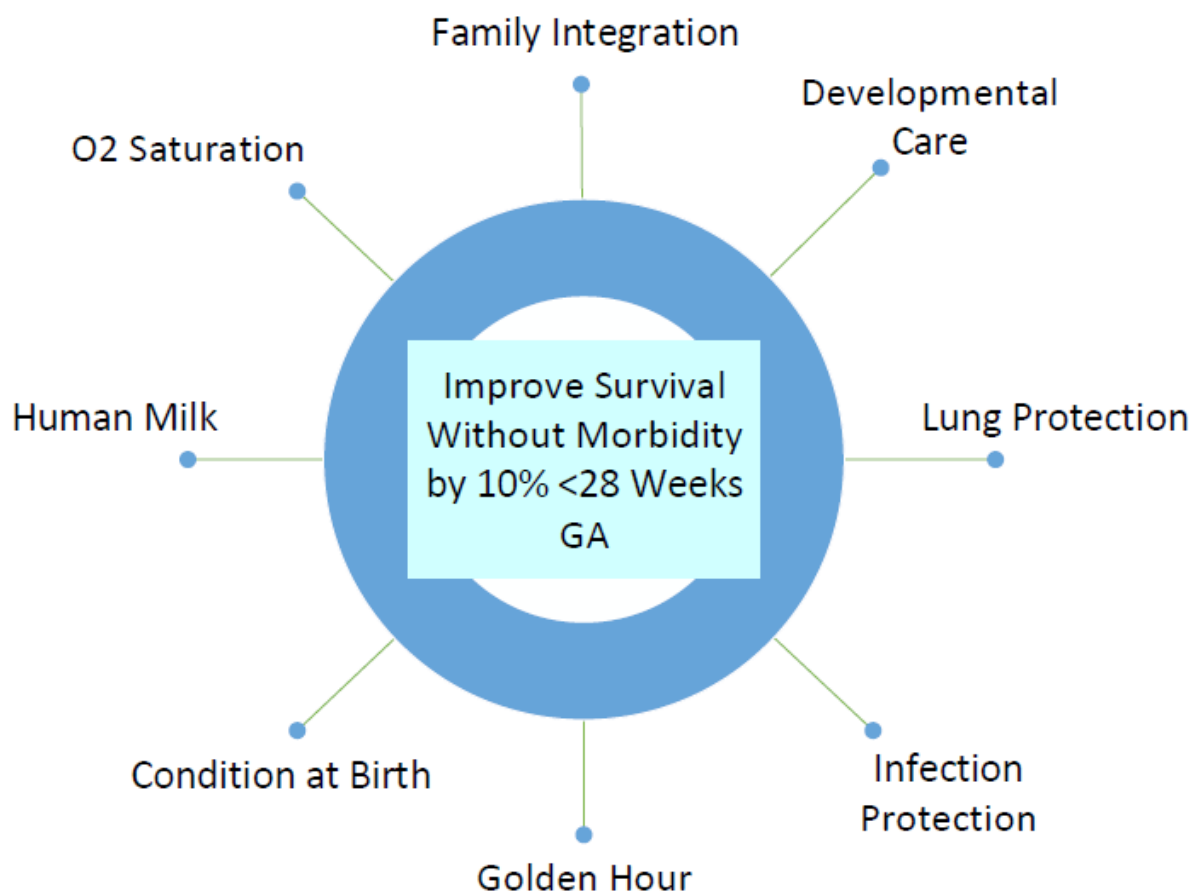
NICQ NEXT2 Micropreemie POD

Drivers of Change:



Mechanisms: The Micro preemie POD has identified multiple Potentially Better Practices (PBP's) in 8 generalized areas of care that may affect survival without morbidity in high risk low birthweight infants. Miami Valley Hospital's overall goal is to implement PBP's in all 8 areas to optimize outcomes. Our team has created a logo that shows the relationship of these PBP's to the general aim of improving survival without morbidity using the theory of Big Dots and Little Dots. We plan on using this logo in all communication with staff about this project. (logo continued on next page)

Drivers of Change Examples Continued



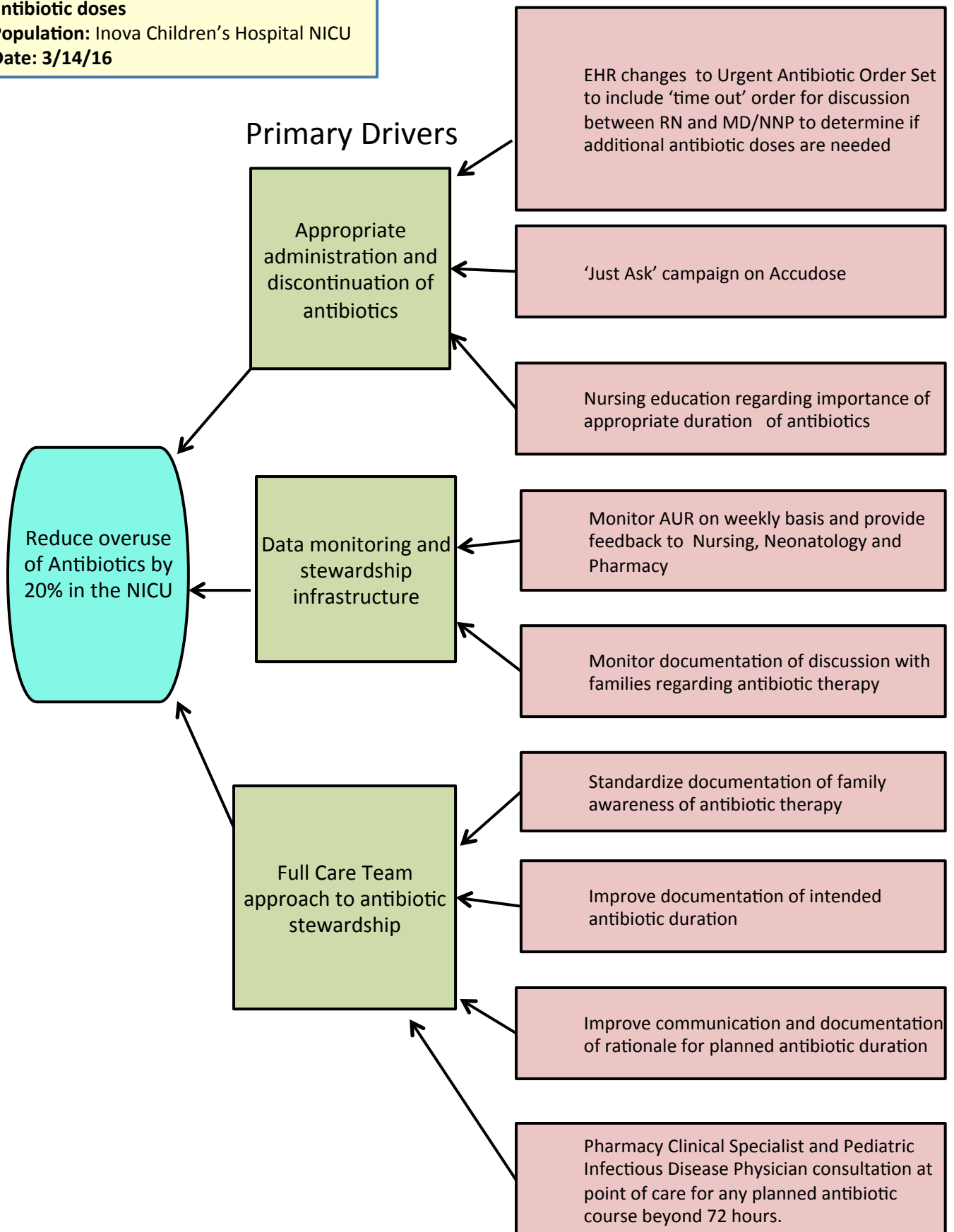
Process: Reduction of inappropriate antibiotic doses

Population: Inova Children's Hospital NICU

Date: 3/14/16

Secondary Drivers

Primary Drivers



“Using Antibiotics Wisely” Driver Diagram

Primary Drivers

Secondary Drivers

Decrease the (over)use of antibiotics in the NICU by 10-12% to include the number of NICU Days solely for antibiotics

1) Strict adherence on all new antibiotics orders to 48 hours (first priority) (NO extra doses antibiotics)

2) For babies treated 7 days (with negative Blood Culture), Strict adherence to 7 days treatment (NO extra doses antibiotics)

3) Decrease number of babies admitted due to maternal Chorioamnionitis

4) Decrease number of babies (asymptomatic) admitted from PACU/FCC in 1st 24 hours for suspected EOS (r/o sepsis)

5) Decrease number of babies in NICU solely for antibiotics

6) Longer term plan: Decrease number of (asymptomatic) babies treated for 7 days with negative blood cultures

- Physician to enter exact number of doses of antibiotics or 48h stop order.
- RN or Pharmacist encouraged to discuss with Physician if no time or antibiotic dose limits ordered
- “Time out” at 48 hours with active decision taken if antibiotics to be continued. Discussion with parent and RN and documentation in chart as to “why”. esp with negative BC
- Discuss with microbiology if 48h “time clock” starts at time of drawing
- Monitoring compliance/progress : weekly “plot the dot” data/charts posted in NICU
- Balancing measures: Monitoring of Blood cultures and “missed doses if BC turns positive”
- Staff training/awareness: all physicians and RNs to be told of new guidelines.

- “Time out” at 48 hours with active decision taken if antibiotics to be continued. Discussion with parent and RN and clear documentation in chart as to “why”.
- Physician will write appropriate number of doses of antibiotics to complete 7 days exactly
- RN or pharmacist encouraged to discuss with Physician if no time or antibiotic doses limits ordered
- Monitoring compliance/progress: weekly data and “plot the dot” charts posted in NICU

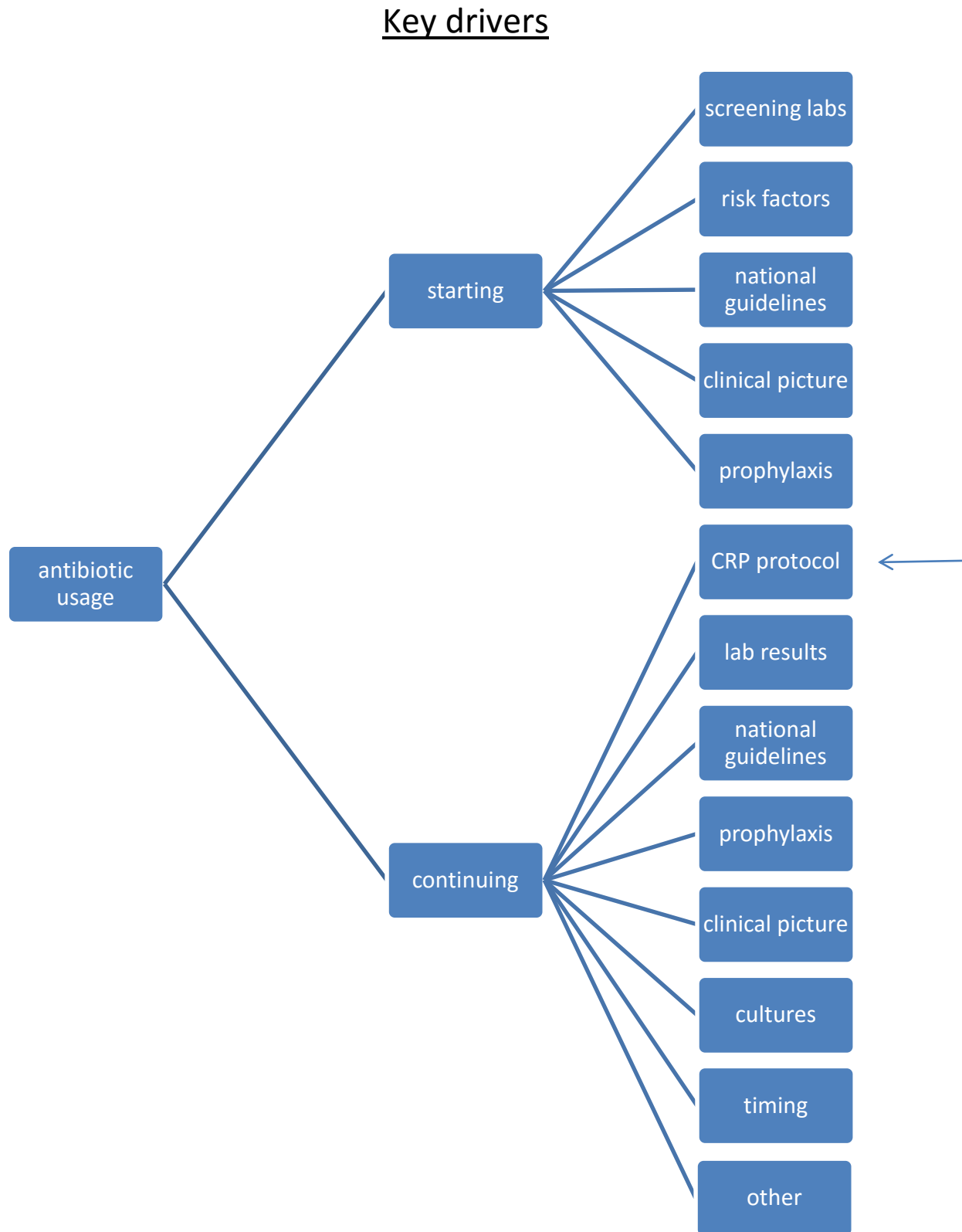
- Reinforce with OB department definition of Chorioamnionitis (Go to meeting)
- ?Post criteria in delivery rooms or somewhere in L&D?
- Physician to discuss with OB prior to admitting baby to NICU?

- Follow CDC criteria or redefine criteria closer to CDC guidelines
- Initial focus on asymptomatic infants with no risk factors, born by scheduled CS with no ROM and asymptomatic infants (with no risk factors) of fully treated GBS+ mothers: NO CBC
- Develop our own “Newborn EOS Screening guidelines” and post in L&D/NRNs education
- ?consider use of CDC GBS App or using “Neonatal Sepsis Calculator”
- Monitoring/balancing measures: these babies to remain in FCC 48h. ?more frequent VS? Keep log of babies who later get sick or need admission? (How long?)

- work on (1) and (3) and (4).
- transfer asymptomatic/BC neg babies to Pediatric unit at 48h (mother can room in and BF)
- Long term plan: transfer babies to FCC if mother still in house (FCC RN training/education)

- redefine criteria for continuation of antibiotics in asymptomatic babies with negative BC
- “Time out” at 48h with active decision to continue – involve parents, RN?
- ?based on maternal history, CBCs, CRPs, Other labs
- Obtain 1 mL for BC to decrease chance of false negative? – downside is delay in obtaining BC and starting antibiotics promptly
- Monitoring compliance/progress: weekly data and charts (AUR)
- Balancing measures: monitoring for positive BC, missed antibiotic dosages, period of observation ? At least initially

2016 Monroe Carell Jr. Children's Driver Diagram Example



CRP protocol provides a 48 hour time out, but since it is ordered at 48 hours some infants get an extra set of antibiotic doses, probable first point of intervention.