

How do we keep them safe,
when this is the safest place
to be

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Objectives

- Identify safety items in the neonatal area
- Discuss maneuvers for each safety item to assist in maintaining safety

Safety Definition - Dictionary

1. State of being safe
2. Device for preventing damage to machinery or injury to workers

Safety Definition - Wiki

1. The condition of being protected against physical, social, spiritual, financial, political, emotional, occupational, psychological, educational, or other types of consequences of failure, damage, error, accidents, harm or any other event which could be considered non-desirable
2. Takes the form of being protected from the event or from exposure to something that causes health or economical losses

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- Wikipedia then goes on to say that:
 - Safety is relative, eliminating all risk, even if possible, would be extremely difficult and very expensive
 - A safe situation is one where risks of injury or property damage are low and manageable

Safety at best performing hospitals

- CPOE, test results, and adverse event reporting
- Specific safety policies
 - Plan in place, AER plans are made, rounds, errors reported and openly discussed, information to right people in a timely fashion
- Use of data from safety programs
- Drug storage, etc
- How AER handled
- Prevention policies

Safety measures – Wiki

- Training, so employees and users know what to do
- Instructions, so there is explanation and demonstration
- Standard protocols and procedures
- Periodic evaluations, of employees and departments
- Root cause analysis, to identify causes of a systems failure and correct deficiencies
- Statement of ethics, so employees know what is expected of them

What are our safety standards

- Orientation
- BLS, ACLS, PALS, NRP, Fetal monitoring classes
- Policies
- Drills, mock codes, critical events, simulation training. Suspension of reality and how are we making it as real as possible.
- Rapid response teams

Culture of Safety

- Do we walk the walk and talk the talk
- Safety Attitude/Safety Climate Questionnaires
 - Aviation identified that most error is human error not mechanical problems
 - Measure and create interventions to improve culture safety
 - Team training
 - Collaboration
 - Shared model
 - Each member advocates for patient safety

AHRQ Safety culture

- In prior surveys, nurses have consistently complained of the lack of a blame-free environment, and providers at all levels have noted problems with organizational commitment to establishing a culture of safety.
- The underlying reasons for the underdeveloped health care safety culture are complex, with poor teamwork and communication, a "culture of low expectations," and authority gradients all playing a role.

No-blame versus a Just culture

- A just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior.
- It distinguishes between human error (eg, slips), at-risk behavior (eg, taking shortcuts), and reckless behavior (eg, ignoring required safety steps), in contrast to an overarching "no-blame" approach still favored by some.

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- In a just culture, the response to an error or near miss is predicated on the type of behavior associated with the error, and not the severity of the event.
 - For example, reckless behavior such as refusing to perform a "time-out" prior to surgery would merit punitive action, even if patients were not harmed.

■ Perinatal Safety Nurse

- Assessed safety in environment
- Team training
- P&P review using national and professional standards
- Documentation review
- Clinical simulations
- EFM common language and all must be NCC certified in EFM

PSN

- Individualized to institution
 - Clinical unit time
 - Patient rounds
 - Outcome data collection
 - Medical record and strip review
 - Case review

How do we create a safe culture?

- Orientation
 - Competency based process
- BLS, etc
 - Verifying that the training is correct
- Have policies available for resources for those tough situations
- Do drills of all kinds and do them frequently enough that the staff is comfortable with the issues that might arise. Make them as real as possible

Safety

- Medication Safety
 - Are the rights of medication administration being done
 - Distractions
 - What is the unit doing to assist when the emergencies happen
 - Medication labels
 - Dosing tables
 - Drills

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- Unit lock downs and abduction codes
 - Is the unit locked down and how is that happening
 - Visitor control and family time
 - Drills
 - Disaster preparation
 - Supplies
 - Drills

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- Discharge teaching
 - All the mandatory items included
 - Car Seat Safety
 - Shaken Baby Syndrome
 - Back to Sleep/SIDS
 - Breast Feeding
 - Hyperbilirubinemia
 - Late Preterm Issues?

Falls

- Out of hospital falls are the most common cause of injury, often from beds or couches.
- Tables, worktops and chairs also but these are a greater height
- 12% were falls out of arms or the person holding the infant fell

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- Large focus on adult and pediatric falls, none on in-hospital neonate falls
 - Falls of neonates
 - Recent article by Monson et al assessed the number of falls in house of newborns in a 18 hospital system.
 - 14 falls/89,000 births
 - 7 with sleeping parent
 - 4 in delivery room
 - 2 in hallway in basinette
 - 1 in NICU

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- Of the 7 falls with sleeping parent the following information is available
 - First day of life
 - Between 0130-0900
 - Both mother and father
 - Sedation medications
 - 32 to 43 inches on linoleum covered concrete
 - One had skull fracture

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- What to do about the items
 - Inform the family and include them in the care, timing and type of falls, also bedtime asphyxia
 - Sedated mothers
 - More frequent observation, secondary person in room, education on what to do when sleepy.
 - Time of day
 - More frequent observation, authors went to every 30 minutes if infant known to be in parent arms between 2400-0900. Also time of increased mortality

- Height issue

- Bed as low as possible, crib as close as possible, in recliner...easier to reach crib when tired?

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- No protocol in place to tell staff what to do once fall happened
 - Risk management
 - Physician notified
 - Xray or CT
 - Physical exam
 - Hold an additional 24 hours