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St. Christopher's Hospital eliminates preventable threats in the NICU

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Deep within the 117 page 2009 annual report of the Pennsylvania Patient Safety Authority is a sliver of light into what neonatal hospitalized patients face. A study from 2006 at St Christopher's Hospital in Philadelphia on ventilator-associated pneumonias (VAP) is shared. VAPs are a preventable medical error.

At St. Christopher's in 2006 after noticing an increased rate of VAPs that were significantly above the national average, the hospital proactively initiated a literature review and collaborated with other pediatric hospitals. Per the report, this "multidisciplinary team implemented a series of revisions to an existing pediatric ventilator bundle to better serve the neonate population."

The changes that were implemented addressed standards for oral hygiene of neonates depending on their gestational age at birth, "securing endotracheal tubes using standard procedures, discarding all tubing and circuits from standby ventilators, altering the frequency of ventilator circuit, tubing, and disposable oxygen equipment changes, adopting a standard for depth of suctioning and suction pressures, implementing a patient flow sheet to document completion of bundle elements."

As a result of this proactive and standardized steps, the hospital continually attained a drop in the incidence of VAPs in the NICU each year, until 2008 when the NICU incurred zero VAPs for an eighteen-month period (between June 2007 & December 2008).

Parents of young patients should appreciate how preventable the infections that are acquired in hospitals. One of the easiest means of preventing infections is proper hand hygiene and compliance to hand hygiene practices. The St. Christopher study specifically noted that hand hygiene compliance was a part of this initiative and continued to improve as the NICU ventilator bundle was continually implemented.

Neonatal patients on ventilators should not be getting pneumonias. If they do, parents and caregivers should look to this study as a means to explain what was not done to prevent the occurrence in their child or their NICU, how to help improve the infant's care, and prevent similar adverse events in the future.

To help build a pedicatric safety community join James' (STB) Project. The 100% volunteer driven project works to inform, protect, unite, and persist to save babies and children in healthcare.

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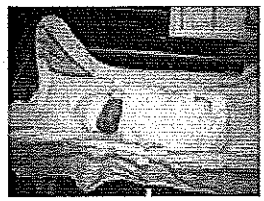

Ventilator associated pneumonias were eliminated in a local NICU.
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