



Healthcare Organization Commitment

Contact Details

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Position

Chief Medical Officer

Organization Name

UCI Health

Commitment Details

How many hospitals are represented in this commitment?

Last Report	Current
1	1

Action Plan

Unplanned extubations have been tracked in the Neonatal ICU (NICU) since 2008. This is reported to the unit for tracking and intervention. Interventions have included elimination of inline suctioning, standardized ET tube holder, bedside safety practices such as two providers for high risk procedures such as suctioning, linen change, chest X-ray. A nursing project focused on unplanned extubations in the NICU population--findings indicated standardized roles and communication would be valuable; subsequent implementation of these practices has occurred. Housewide, a standardized ET tube holder has also been implemented, with isolated exceptions. Investigation is underway to determine if an EMR core data set from Epic is available for analysis and performance improvement. Data on

unplanned extubations are also entered into our incident reporting system for review by Respiratory Care for trends. A difficult airway algorithm is in development to identify patients with known difficult airways. This year 15 additional ventilators were purchased with wave form capnography.

Commitment Update

In the Neonatal ICU the unplanned extubation committee continues to meet to review all cases looking for trends and opportunities for performance improvement. To aid in better visibility of the endotracheal tube and ventilator circuit during surgery, the committee is reviewing the NICU's procedure for draping patients before surgery and evaluating different surgical drape products. In addition a bedside tool displaying the depth and size of the endotracheal tube has been implemented to increase awareness of correct positioning. Housewide, changes were made to the EMR for more detailed documentation on unplanned extubations. These modifications facilitate better data entry and ease of chart review, as well as regular reporting. In addition a difficult airway algorithm has been implemented to identify those patients with known difficult airways.

Other

Challenge 8B - Unplanned Extubation

Please describe any best practices your organization has learned through your commitment and share valuable lessons or challenges that were overcome

A multidisciplinary approach has been the most valuable lesson learned. While modifications in practice made progress toward the goal, the most significant improvement began when the team had representation from all bedside disciplines including physicians, nurses, respiratory therapists and physical therapists.

Impact Details

Initial Commitment	Commitment Update	Project Next Year
Lives Lost 0	Lives Lost 0	Lives Lost
Lives Spared Harm Target 0	Actual Lives Spared Harm in last 12 months 0	Lives Spared Harm Target for following calendar year 0

Lives Saved Target 0	Actual Lives Saved in last 12 months (might differ from initial target) 0	Projected Target of Lives Saved for following calendar to try to finish commitment 0
	New Lives Lost (lives lost – actual lives saved) 0	

Acknowledgement

Yes, I acknowledge that this commitment may be used for external communication and publicly announced at the World Patient Safety, Science & Technology Summit. Furthermore, I agree that this commitment may appear on the website of The Patient Safety Movement Foundation or the Masimo Foundation. I also give permission for my commitment to be used in support of the promotion of the World Patient Safety, Science & Technology Summit as well as The Patient Safety Movement initiative.