Patient Safety Reports in the NICU

The Problem

In the NICU, the number of Patient Safety Reports submitted by nurses and pharmacists was perceived to be low.

Aim/Goal

Communicate and encourage staff to report all near misses and adverse drug events via the Patient Safety Reporting System.

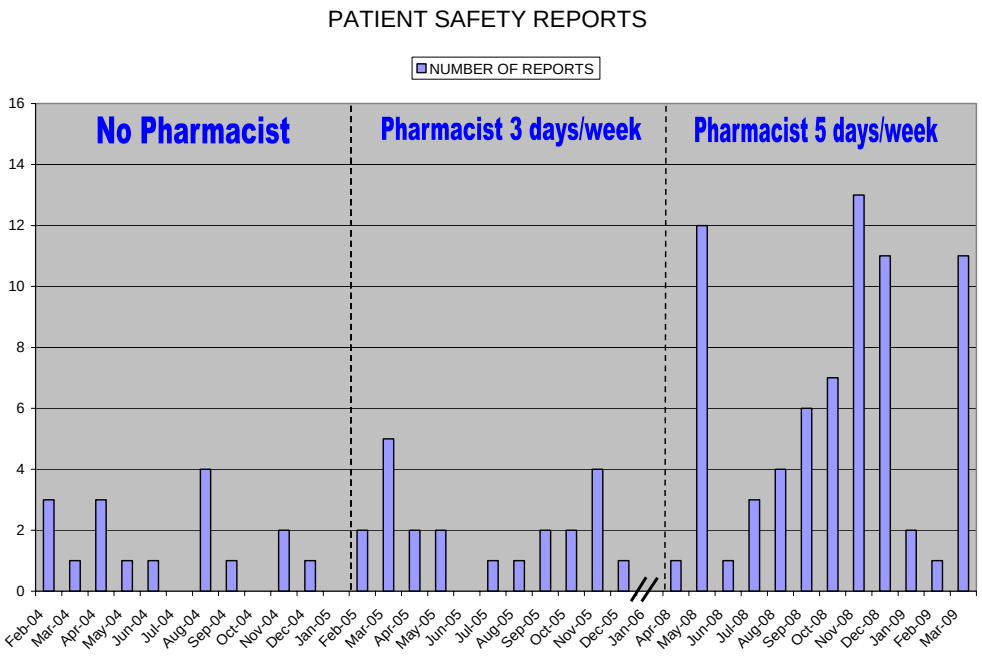
The Team

- Mary Biagiotti, RN, Senior Application Analyst, IS Clinical Application Services
- Holly Creveling, Pharm D., Clinical Pharmacist Supervisor
- Gregory Dumas, RPh, NICU Clinical Pharmacist
- Munish Gupta, , MD, Neonatology
- Francis Mitrano, MS, RPh., Director, Pharmacy
- DeWayne Pursley, MD, Chief of Neonatology
- Mary Quinn, NNP, Neonatology
- Karen Smethers, Pharm D., BCOP, Clinical Coordinator, Medication Safety
- Susan Young, RN, NICU Clinical Nurse Specialist
- Clinical Pharmacists
- NICU Nurses

The Interventions

- A full-time pharmacist was added to the team which cares for infants in the Newborn Intensive Care Unit.
- Staff meetings were convened to review near miss and adverse events; to promote awareness of the same; and to solicit ideas for improving medication and general patient safety

Results/Progress to Date



Lessons Learned

Communication and increased awareness among members of an interdisciplinary team caring for NICU patients promoted increased reporting of near misses and adverse events via the patient Safety Reporting System.

Next Steps

1). Review and utilize lessons learned from submitted cases to make systems changes that will improve patient safety.

2). Maintain meetings and communication to increase the number of reports submitted so that we may continuously improve processes and patient care/safety.

3). Asses the impact on decreasing more serious adverse events.

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