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## Safe Baby

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# Safe Baby

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# Acknowledgements

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  - April Assee MSN, RN, CPHON
  - Jenny Marsh MSN, RN, CPON
- 5 Sutherland Directors
  - Kelli Rafols MSN, MBA, RN, CPN
  - Janette Rowe MSN, RN, CPEN
- 5 Sutherland Quality Improvement Coordinator
  - Mary Copeland BSN, RN, CPN
- 4 Henson and 5 Sutherland Staff

# Background

- There were about 3500 deaths due to Sudden Unexpected Infant Deaths (SUID) reported in the US in 2014.
- Safe to Sleep includes: **(a) provide a firm mattress, (b) remove pillow, blankets, and crib bumpers, (c) remove soft objects like soft toys and loose blanket out of infant's sleep area, (d) nothing should cover the infants head, (e) avoid over-heating the infant, and (f) do not co-sleep.**
- In 2016, the American Academy of Pediatrics (AAP) released an updated policy statement and technical report expanding their recommendations on safe sleep environments for infants.
- Children's Mercy's policy on Safe to Sleep echoes the AAP (2011) policy and the Safe to Sleep campaign. Safe to Sleep has been implemented throughout the organization previously with positive results and improvement in compliance rates. It is important for continued safe to sleep compliance as a model for proper care for when babies go home and to ensure the best care possible.

# PICO Question & Aim Statement

## *PICO Question*

(Population, Intervention, Comparison, Outcome)

**P:** 4 Henson and 5 Sutherland patients who qualify for Safe Sleep Practices according to the Safe Sleep Policy.

**I:** Creating a useable checklist to be completed with each infant and each shift change

**C:** Current standard of care

**O:** Increased compliance with safe to sleep practices



## *Aim Statement*

The objective of this evidence based practice project is to increase Safe Sleep compliance from 50% to 65% on 4 Henson and 5 Sutherland by February 1, 2018.

# Strategic Goal Alignment



## **Demonstrate Quality Outcomes**

Demonstrate quality, safety and clinical effectiveness.



## **Improve Performance**

Improve processes, increase capacity for innovation and service excellence, and strengthen our financial position.



## **Strengthen Market Position**

Strengthen Children's Mercy's market position in the Metro area, region, and beyond.



## **Deliver Value**

Deliver value, expertise, and efficiency through an integrated pediatric health system.



## **Elevate Academic Profile**

Enhance the research capabilities and accomplishments of CMH and strengthen the quality of the educational experiences.

# Strategic Goals (cont.)

- Demonstrate Quality Outcomes:
  - Improve safety of our patients
- Improve Performance:
  - Increase the education of staff and families on Safe to Sleep.



# PDSA Implemented



## 1. Plan: PDSA Cycle 1

Increase awareness of safe sleep practices and track compliance with them.

## 2. Do

Provide a checklist during admission of patients under one and keep at the bedside to be filled out by the oncoming nurse during bedside report.

## 3. Study

Evaluate the number of compliant patients and common barriers to safe sleep at the beginning of each shift.

## 4. Act

Abandon the change

# PDSA Implemented

## Safe to Sleep Checklist

- Side rails up
- All is clear (everything is out of the bed)
- Flat bed
- Educate if needed
- Baby on back
- Always check
- Before
- You leave

Please sign and date when these are checked at shift change (oncoming nurse signs) and list any barriers present. When filled please return to \_\_\_\_\_ mailbox.

Date	Days	Compliant (Y/N)	Nights	Compliant (Y/N)

Barriers noted:



# PDSA NUMBER 2



## 1. Plan: PDSA Cycle 2

Educate staff at unit updates on safe to sleep policy and barriers noted from October 1<sup>st</sup> to February 1<sup>st</sup>.

## 2. Do

Put together a powerpoint on statistics, safe to sleep policies, and common barriers seen on data collection.

## 3. Study

Evaluate redcap survey data post education and compare it to prior data.

## 4. Act

Abandon the change

# PDSA NUMBER 3



## 1. Plan: PDSA Cycle 3

Increase awareness of safe sleep practices through a hospital wide screen saver.

## 2. Do

Contact information systems regarding process for adding a screen saver.

## 3. Study

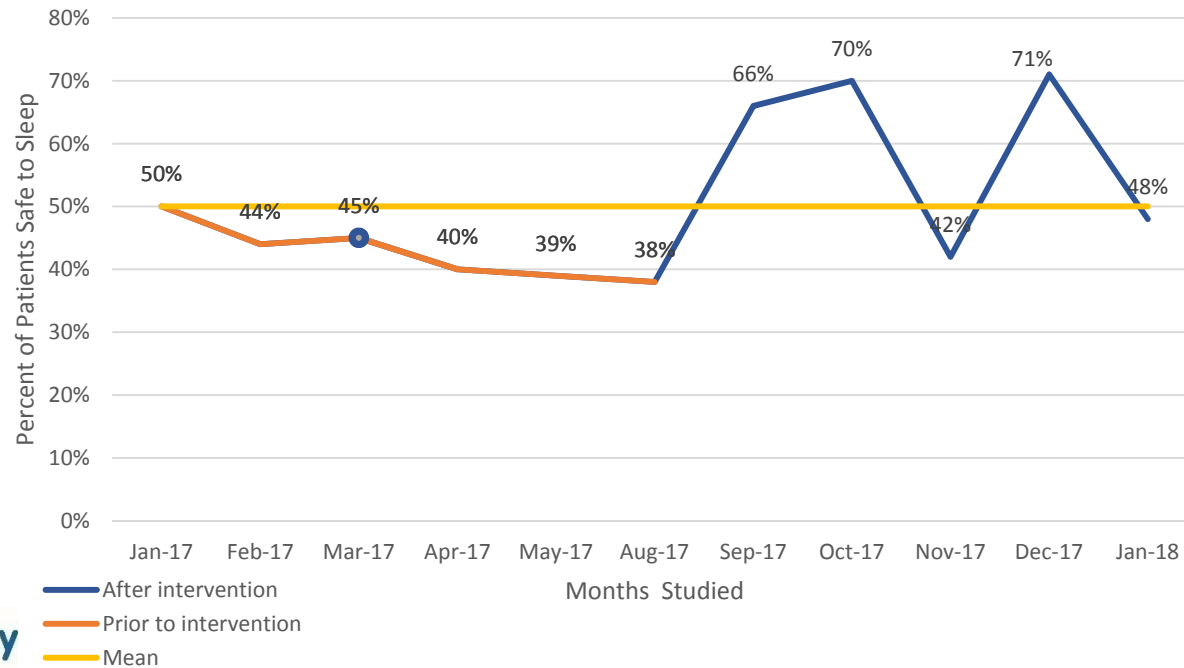
Evaluate redcap survey data after the screen saver has been approved and shown.

## 4. Act

Accept, adapt, or abandon the change.

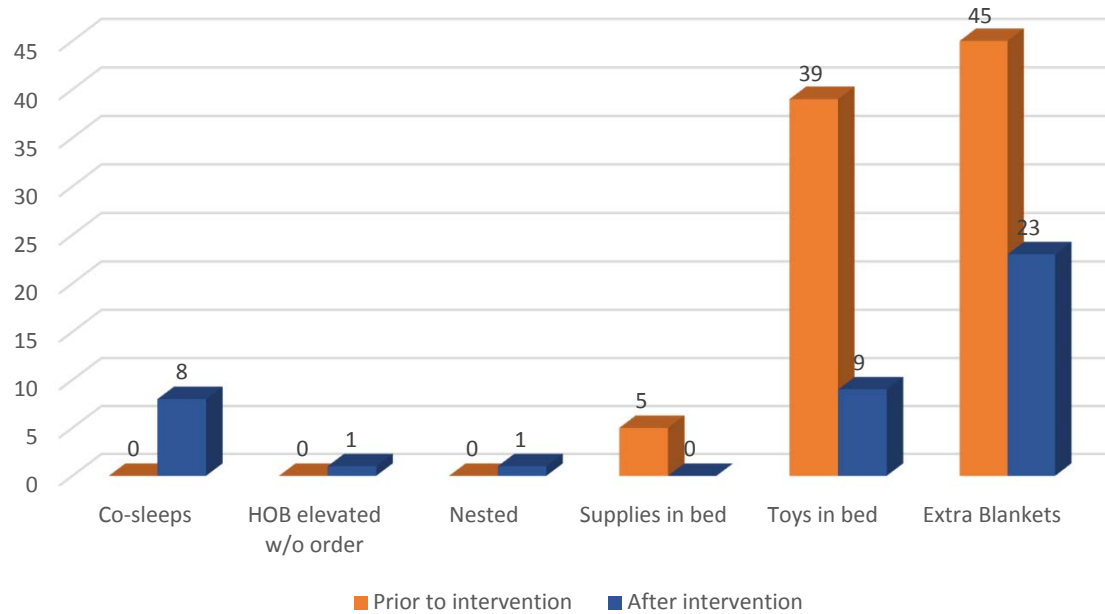
# Project Outcomes

Safe Sleep on 5 Sutherland and 4 Henson



# Project Outcomes

Barriers to Safe Sleep



# Barriers to Safe Sleep

- Previously acquired family routines for sleep
- Cultural barriers
- Staff compliance with Safe to Sleep policy
- Long term patients

# Barriers to Data Collection

- Lack of buy-in by staff on the units (staff non compliance / not filling out checklists)
- Focus on new CMS interventions
- Unit patient population (lack of infants)



# Lessons Learned

- Unit based QI initiatives are difficult to implement due to our barriers and large number of staff members to inform.
- Due to the redundancy of this project topic, it was difficult to implement a new intervention. Because of the previous interventions, staff became confused about which intervention to implement.

# Pediatric Nursing Implications

- Safe to Sleep was implemented to raise awareness of staff and families on the best practices to prevent SUID (Sudden Unexpected Infant Death). Which include SIDS, unknown cause, and accidental suffocation and strangulation.

# Conclusions

- Data collected throughout implementation of the PDSA cycles indicated that there were several barriers to ensuring Safe Sleep practices for all infants on both inpatient units. These were due to blankets in the crib, parents co-sleeping, and babies being nested. Some of our barriers to data collection were previously acquired family routines for sleep, cultural barriers, and lack of buy-in by staff on the units (not filling out checklists). Due to all of these barriers, it was difficult to determine if any real improvement was made due to these interventions.

# References

- Abney-Roberts. (2015). A successful quality improvement project to improve infant safe sleep practice. *J Obst Gynec Neonatal Nursing, 44*, S43.
- Ahlers-Schmidt, C. R., Kuhlmann, S., Kuhlmann, Z., Schunn, C., & Rosell, J. (2014). To improve safe-sleep practices, more emphasis should be placed on removing unsafe items from the crib. *Clinical pediatrics, 53*(13), 1285-1287.
- Colvin, J. D., Collie-Akers, V., Schunn, C., & Moon, R. Y. (2014). Sleep environment risks for younger and older infants. *Pediatrics, 134*(2), e406-e412.
- de Luca, F., & Hinde, A. (2016). Effectiveness of the 'Back-to-Sleep' campaigns among healthcare professionals in the past 20 years: a systematic review. *BMJ Open, 6*(9), e011435. doi:10.1136/bmjopen-2016-011435
- Freyne, B., Hamilton, K., Mc Garvey, C., Shannon, B., Matthews, T. G., & Nicholson, A. J. (2014). Sudden unexpected death study underlines risks of infants sleeping in sitting devices. *Acta Paediatr, 103*(3), e130-132. doi:10.1111/apa.12488
- Macklin, J. R., Gittelman, M. A., Denny, S. A., Southworth, H., & Arnold, M. W. (2016). The EASE Quality Improvement Project: Improving Safe Sleep Practices in Ohio Children's Hospitals. *Pediatrics*. doi:10.1542/peds.2015-4267
- Hauck, F. R., Thompson, J. M., Tanabe, K. O., Moon, R. Y., & Vennemann, M. M. (2011). Breastfeeding and reduced risk of sudden infant death syndrome: a meta-analysis. *Pediatrics, 128*(1), 103-110.
- McDonnell, E., & Moon, R. Y. (2014). Infant deaths and injuries associated with wearable blankets, swaddle wraps, and swaddling. *The Journal of pediatrics, 164*(5), 1152-1156.

# References

- McMullen, S. L., Fioravanti, I. D., Brown, K., & Carey, M. G. (2016). Safe Sleep for Hospitalized Infants. *MCN Am J Matern Child Nurs*, 41(1), 43-50. doi:10.1097/NMC.0000000000000205
- Moon, R. Y., Darnall, R. A., Feldman-Winter, L., Goodstein, M. H., & Hauck, F. R. (2016). SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. *Pediatrics*. doi:10.1542/peds.2016-2938
- Moon, R. Y., & Hauck, F. R. (2015). Hazardous bedding in infants' sleep environment is still common and a cause for concern. *Pediatrics*, 135(1), 178-179.
- Moon, R. Y., Horne, R. S., & Hauck, F. R. (2007). Sudden infant death syndrome. *The Lancet*, 370(9598), 1578-1587.
- NICHD. (2015). *Safe to Sleep® Public Education Campaign* Retrieved from <http://www.nichd.nih.gov/sts/Pages/default.aspx>.
- Moon, R. Y., Darnall, R. A., Goodstein, M. H., & Fern, R. (2011a). SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment. *Pediatrics*, 128(5), 1030-1039. doi: 10.1542/peds.2011-2284
- Moon, R. Y., Darnall, R. A., Goodstein, M. H., & Fern, R. (2011b). SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment. *Pediatrics*, 128(5), e1341-1367. doi: 10.1542/peds.2011-2285
- Rechtman, L. R., Colvin, J. D., Blair, P. S., & Moon, R. Y. (2014). Sofas and infant mortality. *Pediatrics*, 134(5), e1293-1300. doi:10.1542/peds.2014-1543
- Voos, K. C., Terreros, A., Larimore, P., Leick-Rude, M. K., & Park, N. (2014). Implementing safe sleep practices in a neonatal intensive care unit. *J Matern Fetal Neonatal Med*, 1-4. doi: 10.3109/14767058.2014.964679

# Questions

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