QI- Grace Perreira

A woman just delivered triplets via cesarian section at 34 weeks. All of the neonates were immediately taken to the NICU for higher acuity care. One was born at 2100g, one was born at 2000g, and the last was born at 1600g due to intrauterine growth restriction. The one born at 2100g had a positive Coombs test and required phototherapy intervention within 6 hours of life. In an effort to keep the triplets' care plans separate, they were placed in an open room with individual radiant warmer beds. Their boards were labeled with their first names and birth weights, however the nutrition plans got mixed up. They were all receiving mother/donor milk; however, the kcal additives were not distributed properly, and the wrong baby was administered cream for more than half of the feedings. This resulted in the smallest of the three not gaining sufficient weight and therefore showing signs of failure to thrive. The discrepancies were not documented as incorrect since the documentation was easier to keep organized than the actual care. The mistake was only identified when a nurse in the same pod as the triplets noticed the wrong volumes and recipes given by another nurse.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

The patient care was compromised by nurses administering the incorrect nutrition to the babies and the milk tech's for not sufficiently checking orders for the milks. This could've been corrected with organizing their milks better, color coding everything pertaining to the care of the babies, and adequately scanning all the milk. The triplets also need to be split up for nurse assignments, allowing at least 2 nurses to work together to provide care. This means the situation also falls on the charge nurse.

What circumstances led to the occurrence?

Nurses tend to rush the nutrition step of cares because a lot of the babies just get a gavage feeding. There's usually a lot of scanner difficulties on the unit too, which hinders the scanning process for the milks. Not having a system in place to identify each baby in a quick and easy way, such as color coding with stickers, allows for errors like this to happen.

In what way could you measure the frequency of the occurrence?

There would need to be an interview process for all nurses who had taken care of the triplets in order to identify where and what went wrong as well as why. The weights would be trended for

all of the babies to ensure stable gaining. The intake and output would also be trended for the babies to ensure optimal urinary output. At some point the intake & output alone would raise a lot of red flags for the provider.

What Evidence based ideas do you have for implementing interventions to address the problem?

Ensuring the equipment works on the unit ensure less room for error. The scanners need to be functional so all milk products can be scanned before administration. Having multiple nurses responsible for the care of the triplets every shift is an easy way to encourage collaboration and verification of milks given. Splitting up the care times so that the billi light baby and one other baby gets cares at 8-11-2-5 and the remaining baby recieves cares at 9-12-3-6 would significantly minimize the risk of errors, as well. Color coding supplies and equipment isn't necessarily evidence based, but it would solve this problem immediately. For example, we have baby green, baby purple, and baby yellow. Each one gets their own roll of coordinating colored dot stickers to put on the radiant warmers, the charts, the milk labels, everything.

How will you measure the efficacy of the interventions?

Like I said above, I would trend the weights and the I's & O's of each baby. I would also interview the nurses for a follow-up to ensure that they are not only adhering to the interventions but finding them helpful. These interventions would ensure patient safety as well as protect the nurses caring for them, so I need to evaluate both sides of the puzzle in order for this to be successful.