Reducing Serious Safety Events in a Children’s Hospital

Overview
Yale New Haven Children’s Hospital wanted to be among the safest in the country, but had an inadequate system for reporting safety events and no mechanism to identify, or follow-up on, serious safety events (SSEs). The lack of a system structure left many harm events unreported. This problem inspired an new focus on safety, and with improved recognition and interventions, eventually decreased the rate of SSEs to zero.

Objective
Identify all SSEs and decrease the number of SSEs to ≤ 2/year or a SSE rate of ≤ 0.2/10,000 adjusted patient days within four years.

Methods
The project team member opted to use a model for improvement methodology with multiple Plan-Do-Study-Act cycles. They identified five key drivers and implemented 12 interventions related to those key drivers. While the aim was to reduce the SSE rate, two interventions were partially directed at increasing the ability to identify SSEs, which also increased the SSE rate.

Key Drivers
- Identify all safety events
- Develop a culture of safety
- Staff and provider engagement in safety
- Resolve all safety events
- Proactively detect latent safety threats

Lessons Learned
This project showed that culture change, led by a small group focused on developing simple but thoughtful interventions, could have a substantial impact on hospital safety.
- The morning huddle, attended by unit leaders, medical directors, ancillary staff leaders and open to frontline staff, was a concept that could be easily replicated by other patient care areas.
- SSEs can happen in any area that provides patient care; engage all departments early on in the improvement work to see the whole picture and ensure a standard approach.
- The culture work was a critical component. While a significant amount of time was focused on building infrastructure, it’s essential to align the goals of all staff members.

“...The project is phenomenal. By increasing serious safety event reports, they increased their culture of safety, increased the rate of near misses to SSEs and actually eliminated SSEs down to the holy grail of zero events. The key driver is comprehensive. The plan is very strong. The financial impact is staggering.”

—2017 PQA judge

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