Child Health Patient Safety Organization

Inside the nation’s only PSO dedicated to preventing avoidable harm in children’s hospitals.

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Learning about Child Health PSO

**Child Health PSO is focused on early awareness and shared learning from analysis of reported case events, concentrating on the most serious harm.**

**Stronger Together in Safety**

More than 50 children’s hospitals report safety events to the Child Health Patient Safety Organization (PSO) each month. These events are aggregated and used across all the PSO member hospitals to learn and drive improvement. While the overall goal is a system of high reliability with zero harm, we know that serious patient harm continues to occur. No patient, family member or caregiver wants to see harm repeated. That’s why being part of a safety network where hospitals learn from each other can prevent harm before it occurs. No longer should an adverse event occur within multiple organizations before preventative steps are implemented.

Prior to the establishment of federal Patient Safety Organizations, many hospitals and providers were reluctant to participate in such a learning network. Child Health PSO was created in 2010 with the foresight and passion of children’s hospital leaders who recognized the opportunity for federal privilege and confidentiality protections to allow them to break the silence around sharing harm events. Child Health PSO has achieved the intent behind the Patient Safety and Quality Improvement Act of 2005 (PSQIA) and the PSO founding members. This annual report explains how.

**HOSPITAL STORY**

**Ventriculoperitoneal shunt valve malfunction event reported**

When a ventriculoperitoneal shunt revision due to a valve malfunction was reported, PSO members immediately took action to determine their hospital’s risk. One hospital shared how this (and other) information was useful. “Within 24 hours, we confirmed the product was used in our hospital and notified neurosurgeons of the risk. They weren’t aware of the issue and appreciated the information so they could monitor patients potentially at risk for shunt malfunction.”

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**PSO MEMBERSHIP GROWTH**

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<tr>
<th>2010</th>
<th>2013</th>
<th>2016</th>
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<td>10</td>
<td>40</td>
<td>55</td>
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**CHILD HEALTH PSO MEMBERSHIP**

More than 50 children’s hospitals across the U.S. are part of this pediatric network focused on safety. Even though state protections may be strong, federal protections of a PSO allow learning and sharing “outside” the state and from providers historically silenced. Shading indicates state locations of Child Health PSO members.
Child Health PSO Structure

**How it Works**
As an organization dedicated to advancing child health within children’s hospitals, CHA has invested in patient safety efforts by developing and operating the Child Health PSO and providing support to Children’s Hospitals’ Solutions for Patient Safety (CHSPS).

Child Health PSO is a non-profit entity with a Board of Directors and federally certified by the Agency for Healthcare Research and Quality. Child Health PSO coordinates with CHSPS staff for Safe Table support and to reinforce high reliability methods aligned with CHSPS culture work. Child Health PSO provides the confidential venue for applied shared learning.

**PSO active learning**
- **Federal protections**
  - Low frequency
  - High harm
  - Events with a root cause analysis

**CHSPS active learning**
- **High frequency**
- Evidence-based bundles
- Hospital-acquired conditions

**Expert-led Learning and Analysis**
Safety leaders are experts in detection, analysis and system design to mitigate the risk of preventable harm. In children’s hospitals, safety leaders are experts in the nuances of a delivery system specialized for children and families. This combined knowledge is essential to eliminating preventable harm in children’s hospitals. Child Health PSO is led by an experienced volunteer workforce of safety leaders from children’s hospitals, called the Child Health PSO Patient Safety Team. They meet often to analyze cases in a “safe” (protected) environment. All PSO member hospitals abide by the principle of All Teach, All Learn. Hospital participants engage in analyzing, sharing and teaching during regularly scheduled “Safe Table” events. The recent results of this process are highlighted on pages 5-6.
The Value: Active Learning

Annual Meeting
The annual meeting is an opportunity for Child Health PSO members to meet for Safe Table learning and hear inspirational messages about eliminating preventable harm. This meeting has been co-located with CHSPS and the CHA Quality and Safety Forum.

<table>
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<tr>
<th>ANNUAL MEETING PARTICIPATION*</th>
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<tr>
<td>2011</td>
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<td>2014</td>
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<td>2016</td>
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<tr>
<td>9 HOSPITALS</td>
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<td>41 HOSPITALS</td>
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<td>42 HOSPITALS</td>
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*The PSO has grown from 10 hospitals to 55 to date.

Safe Table Huddles
Safe Table Huddles serve as the Child Health PSO’s early warning system by providing an opportunity to meet briefly (approx. 10 minutes) by phone each week to discuss the past week’s safety experience across the nation. This alerts PSO members of possible safety risks and recruits help from peers to improve case investigations.

<table>
<thead>
<tr>
<th>SAFE TABLE HUDDLE EXPANSION</th>
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<tr>
<td>2013*</td>
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<td>9 HOSPITALS</td>
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<tr>
<td>18 HOSPITALS</td>
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<td>43 HOSPITALS</td>
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*Huddles initiated and tested by the Patient Safety Team through 2015.

Safe Table Case Reviews
Safe Table Case Reviews fulfill the principles of All Teach, All Learn by regularly providing a virtual opportunity to hear how children’s hospitals approach investigations and action planning for harm themes. Examples:

- Alarm management
- Diagnostic error - When the pieces of the puzzle just don’t fit
- Failure to monitor nephrotoxic drugs
- Medication event with an outside pharmacy
- PIV infiltrate with tissue damage
- Sharing events that continue to occur in the operating rooms and interventional radiology suites
- The complexity of medication administration

Patient Safety Alerts
Patient Safety Alerts are timely notices of serious patient harm vulnerabilities at hospitals caring for children. These alerts are shared with PSO members and made available publicly to keep all pediatric patients safe from harm.

- Silicone-Foley catheter balloon rupture
- Recognition of retained foreign body – button battery
- Pediatric medication concentration standards with retail pharmacy
- Medication dosing – receiving liquid medications through an enteral route*
- Fingertip amputation
- Sustained/extended release medication fill and administration errors
- Cutaneous fungal outbreak associated with hospital linens
- Wrong-size tracheostomy selection
- Blind pediatric NG tube placements*

See more at childrenshospitals.org/alerts for future alerts

*Safety alert led to efforts to do more to improve safety nationally.
What’s Behind the Data

Understanding Safety Risks
Of great interest is seeing data to understand where children’s hospitals are most vulnerable and what actions can prevent avoidable harm. Seeing the data is dependent on three things:

1. **Report frequency.** Since cases are voluntarily reported, we know data in the PSO today under represents the breadth of harm experienced. While the available data are valuable and are used to mitigate harm risk, improved reporting will increase shared learning.
   - Customized monthly data submission status reports have been implemented to improve routine submission of cases.

2. **Good case reports.** Complete case reports are important components to understanding safety risks. Inclusion of root causes, contributing factors, and strong action plans add to our patient safety knowledge to reduce the risk of repeat harm events.
   - Training continues to be provided to member hospital staff on submission of quality case reports and will become more targeted by hospital in 2017.

3. **Good data categories.** The national Common Format used by PSOs is an industry agnostic taxonomy required to participate in the national Network of Patient Safety Databases (NPSD). The Common Format is expected to allow for a national understanding of patient safety. However, PSO members need actionable data and most use Healthcare Performance Improvement (HPI) taxonomy. Both need deeper pediatric specificity.
   - Taxonomies have been leveraged to meet the priorities for actionable information, national reporting and minimal manual reporting.

HOSPITAL STORY

Improving event investigations
After a serious event occurred, the hospital’s quality leader recognized it was a similar event reported by the PSO. “This was addressed with my CEO (they meet every two weeks to review safety concerns). Knowing another children’s hospital experienced this enabled my leadership to focus on the system issue rather than what appeared to be a competency issue. This will impact how the event is investigated for action, improves effectiveness of implementation and save time and resources.”

Getting to Actionable Information
Based on three years of case reviews, the Patient Safety Team set an aim to eliminate repeat harm using the holistic patterns from case reviews along with data analyses. Three safety priorities were set for children’s hospitals to evaluate while attending the annual in-person meeting. Together they identified the top priority interventions and possible implementation actions for all to take.

REMEMBER EVERY CHILD BEHIND THE NUMBER*

1,987 CASE SUBMISSIONS  515 SERIOUS SAFETY EVENTS

*Voluntarily reported cases to the PSO to date
The Safety Priorities
In 2016, three areas of repeat harm were prioritized for action through in-depth data analysis by the Patient Safety Team.

High-risk Population: Diabetes Care
- More children are being diagnosed with diabetes; managing their care is challenging as the disease process can be complex and lead to other co-morbidities.
- Patients with diabetes and their families are constantly managing their carbohydrates, glucose and insulin.
- If the symptoms of diabetes complications are not recognized early, the outcomes can be life threatening.

Procedural: Retained Foreign Objects
- TJC Sentinel Event #51 (October 17, 2013)
- Frequently reported event type to the PSO – the modified equipment is often involved and double checks do not appear to be working.
- One issue seems to be related to objects used in pediatrics not typically included on count checklists.

Product/Devices: Thermal Injuries
- Thermal devices are used in various clinical settings and can cause serious harm e.g., severe burns, pressure ulcers, scarring.
- Hospitals can misuse products for patient care by manipulating for pediatric use, disregarding manufacturer guidelines, using for unintended purposes, or creating workarounds when unavailable.

Eliminating Repeat Harm
After the Patient Safety Team prioritized the cases and identified themes, pediatric experts were engaged to develop an initial prioritized process map. Additional content expertise and industry knowledge will be leveraged to complete identification of safety bundles. Next steps focus on identifying the top causes of patient harm and interventions for all to implement.

1. Prioritize data. From reported data, identify top themes and trends
2. Process map. Identify process steps, possible failures and strategies to mitigate risk
3. Prioritize map. Identify priority steps putting organizations at greatest risk
4. Action plan. Patient safety team and member experts identify actions proven, or expected, to eliminate harm
5. Implement. Provide a practice bundle to pilot and test
Advancing Federal Protections

Legal Landscape Advocacy
Beginning with the 2012 Walgreens case in Chicago, Ill., which ultimately resulted in a favorable outcome upholding the federal protections of patient safety work product (PSWP), cases to follow in Illinois and other states have varied in their interpretations.

Members of Child Health PSO receive frequent opportunities to learn from case findings and share policies. For example, Norton Children’s Hospital in Kentucky has shared their experiences and strategies to address reporting mandates in their state that would otherwise limit their ability to participate in shared learning within the PSO to improve pediatric safety.

Child Health PSO provides training and advises PSO members on the importance of their patient safety evaluation system and documentation procedures to provide a backbone to PSQIA privilege and confidentiality protections.

Child Health PSO continues to support efforts resulting in good interpretations of the PSQIA, and has several efforts with that aim.

- **Amici Curiae (aka, friends of the court).** Child Health PSO has participated in several Amicus Briefs with the American Hospital Association, American Medical Association, The Joint Commission and other PSOs to offer state cases our combined understanding of the PSQIA.

- **National Association of PSOs (NAPSO).** This is an informal network of PSO leaders that meet by phone regularly and in person at the Agency for Healthcare Research and Quality (AHRQ) annual PSO meeting to discuss implementation.

- **Legal Officers and Risk Managers.** An informal network of legal officers and risk managers recently expressed interest to connect and communicate more regularly with the PSO on regulation and court cases.

Advancing Pediatric Safety

Impacting Repeat Harm
Our work in Child Health PSO has established a confidential opportunity for children’s hospitals to eliminate preventable harm. Action planning and implementation will be the focus in 2017, along with ongoing analysis that examines and prioritizes top vulnerabilities for patients in children’s hospitals. Specific aims will be set with the expertise of the membership engaged in All Teach, All Learn so all accelerate the elimination of repeat preventable harm.

Children’s hospitals participating in Child Health PSO are industry leaders in pediatric safety with access to pediatric safety information available nowhere else and the opportunity to contribute to an indispensable body of knowledge. It’s a small investment in your efforts to keep each child in your hospital safe.

Qualifying for Health Insurance Exchanges under a PSO
Participation in the Child Health PSO satisfies a new hospital quality standard as part of contracting within the Health Insurance Exchanges effective Jan. 1, 2017.
Acknowledgments

Child Health PSO Board of Directors
Patricia DePompei, PSO Chair, President, UH Rainbow Babies & Children’s Hospital
Christopher Gessner, President, Children’s Hospital of Pittsburgh of UPMC
Thomas Kmetz, PSO Secretary/Treasurer, Division President, Norton Children’s Hospital
James Shmerling, DHA, FACHE, President and CEO, Connecticut Children’s Medical Center
Tom Shufflebarger, PSO Vice Chair, Executive Vice President and COO, Children’s of Alabama

Patient Safety Team
Nina Rauscher, MS, RN, CPHQ, Boston Children’s Hospital (Chair)
Anne Dykes, RN, MSN, ACNS-BC, CPEN, Texas Children’s Hospital
Michaeleen Green, BA, Ann and Robert H. Lurie Children’s Hospital of Chicago (Chair Elect)
Patrick Guffey, MD, Children’s Hospital Colorado
Tamara Johnson, BSN, CPHRM, Phoenix Children’s Hospital
Carol Kemper, RN, PhD, CPHQ, CPFS, Children’s Mercy Kansas City
Fiona Levy, MD, MBA, NYU Langone Medical Center
Jeanann Pardue, MD, East Tennessee Children’s Hospital
Jeanette Teets, RN, MSN, CPNP, The Children’s Hospital of Philadelphia

Children’s Hospitals’ Solutions for Patient Safety
Missy Shepherd, PM, Executive Director
Emily Oehler, Project Manager
Jeanette Teets, Culture Leader
Laurie Stevens, Project Specialist

Child Health PSO Contacts
Kate Conrad, FACHE, Vice President
913-981-4118
kate.conrad@childrenshospitals.org

Barbara Weis, Manager, Patient Safety
913-981-4117
barbara.weis@childrenshospitals.org

Emily Tooley, RN, MSN, Analyst, Patient Safety
913-981-4130
emily.tooley@childrenshospitals.org

Cindy DuMortier, Coordinator, Patient Safety
913-981-4146
cindy.dumontier@childrenshospitals.org