Photo: Christopher Phillips, Children's Minnesota, Minneapolis, MN

Resilience in Action

Child Health Patient Safety Organization®

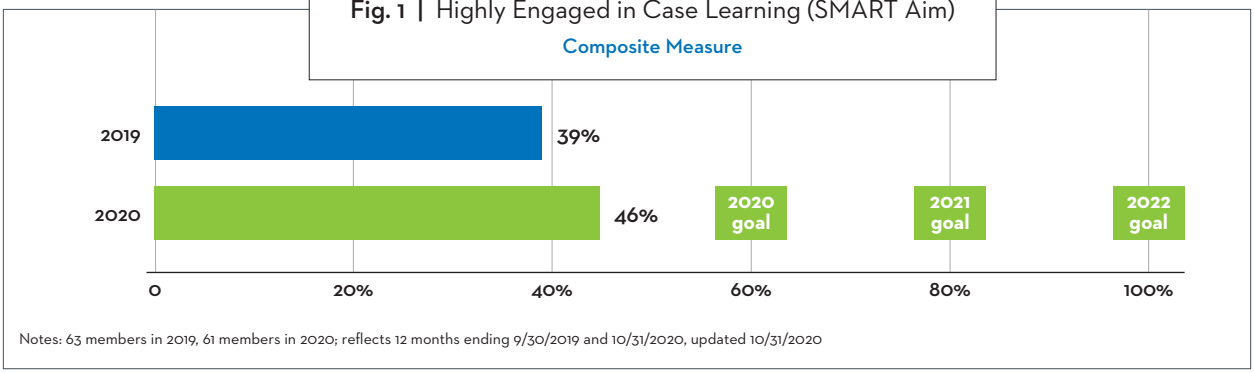
2020 ANNUAL REPORT

Improvements in patient safety are accelerated by learning from instances of patient harm and anticipating what could go wrong. Participating in the Child Health Patient Safety Organization (PSO) supports both. By understanding events that lead to patient harm at peer institutions, children's hospitals are positioned to proactively assess and mitigate preventable pediatric patient harm and become more resilient institutions. Because we learn together, children are spared preventable harm.

The engagement of children's hospitals through the PSO learning network has been remarkable over the past year—a period of unprecedented health care delivery disruption. The overall case learning composite measure increased by 7% to achieve 46% of children's hospitals being highly engaged in the PSO (see figure 1). This composite measure reflects 54% of children's hospitals submitting two or more cases over the last year, a 10% increase from 2019. It also includes more than doubling the Safe Table attendance highly engaged metric.

Fig. 1 | Highly Engaged in Case Learning (SMART Aim)

Composite Measure



Notes: 63 members in 2019, 61 members in 2020; reflects 12 months ending 9/30/2019 and 10/31/2020, updated 10/31/2020

CHILDREN'S HOSPITAL ASSOCIATION

The highest standard of engagement in weekly Safety Huddles (the PSO's early warning system), 80% attendance, was achieved by 65% of children's hospitals, which doubled engagement from the prior year. Sixty-one percent of participating children's hospitals achieved the highest standard in huddle reporting, providing a richer learning system for all to anticipate potential harm. Each organization's engagement is summarized in a hospital-specific report available as a companion to this annual report.

Cognitive bias, diagnostic errors, situational awareness and communication failures have been prioritized from the Patient Safety Team's triannual analysis of cases submitted by children's hospitals. These themes have driven our case learning from monthly Safe Tables, alerts and the annual meeting.

This year's annual meeting focused on applying Safety II principles within the procedural and surgical microsystem, which reflects 15% of cases analyzed (figure 2). The topic, and our virtual format, provided an opportunity to extend the learning to participants in the Quality and Safety Leaders and the Pharmacy Leader Forums. The meeting content included learning about personality styles in teamwork, understanding Safety II and its application during COVID-19, reinforcing resiliency through simulation, and optimizing the Children's Surgery Verification program. These themes are consistent with causal factors identified in cases reported (figure 3).

While children's hospitals share a journey to eliminate preventable pediatric patient harm, each has different local drivers and priorities in patient safety, especially as we work toward stabilizing our organizations over the coming year. In 2021, we will introduce a new PSO support team and invite you to share how Child Health PSO can best support your organization's goals in being safer together.

Thank you for your efforts as part of the Child Health PSO, especially contributors to the Diagnostic Safety Toolkit, Safe Tables, annual meeting, and, most importantly, case reporting. Thank you to the Child Health PSO Board of Directors and Patient Safety Team and our partners at the Solutions for Patient Safety and NextPlane Solutions LLC, for providing the support children's hospitals need to eliminate preventable pediatric patient harm.

CONTINUING OUR WORK

Child Health PSO has successfully recertified through October 11, 2023.

ANNUAL MEETING

Nearly 350 attendees from 67 children's hospitals, as well as 97% of PSO members, were represented during the virtual series.

SAFETY TOOLKIT

Ninety children's hospitals, including most PSO members, and 43 other organizations from nine countries downloaded the Diagnostic Safety Toolkit.

Fig. 2 | Top 3 Event Categories

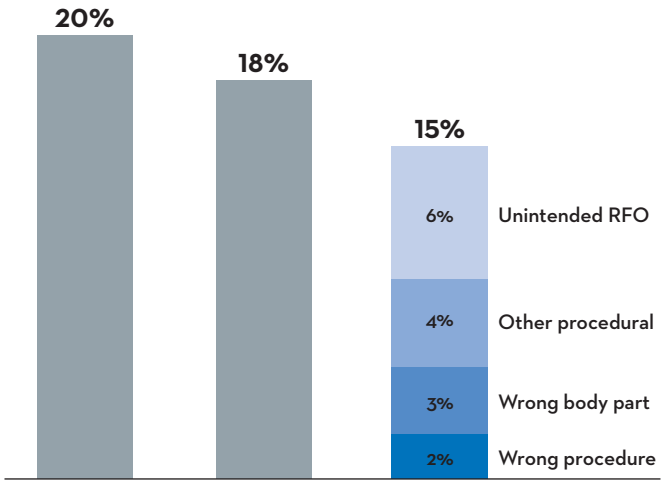


Fig. 3 | Procedural Event Causal Factors Compared to All