2023 ANNUAL REPORT

Safer Together

Child Health Patient Safety Organization®

The Child Health Patient Safety Organization (PSO) strives to help children's hospitals make patient care safer. Guided by the collaborative work of nearly 60 member hospitals, the PSO provides unmatched resources to help children's hospitals mitigate preventable harm to children. As the only PSO in the nation solely focused on children's hospitals, it offers unique opportunities to confidentially explore harm in pediatric settings through shared learning with other children's hospitals.

According to the Office of Inspector General, 80% of hospitals that participate in a PSO say feedback and analysis on patient safety events have helped prevent future patient safety events.* Because of its federally protected status, the PSO is one of the only places hospital leaders can safely learn from one another's mistakes. This is made possible by a certification from the Agency for Healthcare Research and Quality (AHRQ) that allows member hospitals to share safety cases, discuss solutions and address challenges confidentially and voluntarily. Earlier this year, the AHRQ recertified the PSO through Oct. 2026, allowing its vital work to continue uninterrupted.

The PSO facilitates learning among members through monthly safe tables, weekly huddles, alerts, the annual meeting and more. The PSO capitalizes on lessons learned from these engagements to develop crucial resources to advance patient safety throughout the industry and timely tools to equip our members in their hospitals. This year marked several highlights in learning and development.

PSO by the Numbers

59 member hospitals

3372 early warnings

2089 events analyzed

17 alerts

CHILDREN'S HOSPITAL ASSOCIATION

Diagnostic safety improvements

Accelerating diagnostic safety was a focus in 2023. We collaborated with the American Academy of Pediatrics (AAP) on their grant, "Improving Diagnostic Excellence in Ambulatory Pediatrics." That work created several educational videos highlighting the Child Health PSO Diagnostic Safety Toolkit that was originally released in 2020. The PSO is also working with CHA's Quality Improvement team to pilot a project to assess how the implementation of certain portions of the Diagnostic Safety Toolkit affected hospital safety efforts.

Enhanced data

The PSO began the process of migrating to a new data platform to enhance member support while improving demographic data collection. The switch to Riskonnect provides expanded diversity, equity and inclusion metrics as well as the ability to score action items and align huddle submissions. With go-live anticipated in early 2024, our focus remains on balancing the ease of entry with actionable output, thereby strengthening our learning opportunities.

Industry influence

In the spring, we shared the work of our multi-center safety huddle at the Pediatric Academic Societies Meeting along with a poster that outlined the PSO's efforts to use a "huddle intervention" to drive engagement. Implementation increased both the number of participants and safety reports. The retrospective study is being considered for publication, and it is anticipated to be another significant recognition of children's hospital leaders working together and the contributions of patient safety organizations.

Looking forward

As we move forward in 2024, sparing children from serious preventable harm will continue to drive our shared purpose. We will evolve to ensure children's hospitals have the right options to improve patient safety while building upon established partnerships, such as our work on diagnostic safety with the American Academy of Pediatrics and CHA Quality Improvement Team. We will continue to analyze and monitor the development of new recommendations from the President's Council of Advisors on Science and Technology (PCAST) to help members evaluate and potentially implement changes. Lastly, we are exploring how to best apply SAFER guides to prevent safety events due to technology errors.

We offer a sincere thank you to our member hospitals that contributed so meaningfully to our work this year. The PSO's efforts to keep children safe depends on your participation. Thank you as well to the Child Health PSO Board of Directors, the Patient Safety Team, and our partners at the Solutions for Patient Safety and Press Ganey Associates for supporting children's hospitals. We look forward to continuing the learning network journey together in the next year!

2023 by the Numbers

50

safety huddles

Members discuss real-time events during these virtual gatherings, enabling early warning of safety issues and timely prevention strategies.

13

safe tables

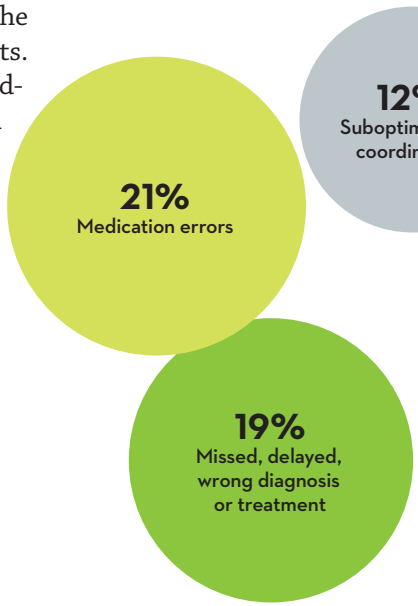
Safe tables feature a safety case from a children's hospital, helping members learn from the experience and reduce harm at their organizatons.

90

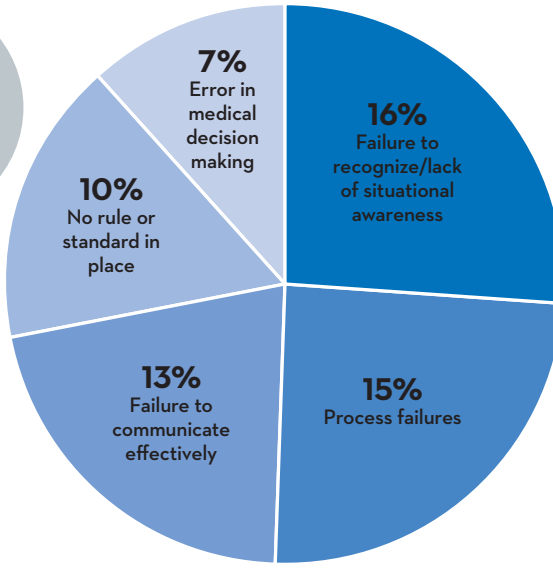
annual meeting attendees

This year's meeting topics, included artificial intelligence, cognitive traps leading to diagnostic errors, effective decision tools and more.

Top event categories



Top event causal factors



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*"Patient Safety Organizations: Hospital Participation, Value, and Challenges Report" (2019).
Photo: Allyn DiVito, Johns Hopkins All Children's Hospital