Photo: Ingrid Barrentine, Mary Bridge Children's Hospital & Health Center, Tacoma, Washington

Building Resiliency

Child Health Patient Safety Organization®

2019 ANNUAL REPORT

Celebrating 10 years together

Learning from multi-center reported serious safety events, children's hospitals celebrate 10 years of opportunity to learn together to improve safety under Child Health Patient Safety Organization's (PSO) privilege and confidentiality protections. In this time, over 1,200 cases have been analyzed and over 1,300 early warnings have been shared so your hospital can improve patient care without another child having to experience serious harm.

Building organizational resiliency

At the 2019 PSO annual meeting, organizational resilience discussions focused on how children's hospitals can broaden methods to eliminate preventable serious harm using Safety I and Safety II principles. A system is resilient if it can adjust its functioning prior to, during, or following events (changes, disturbances and opportunities) and thereby sustain required operations under both expected and unexpected conditions.[1] Safety leaders analyzed what worked well using a systematic non-linear approach.

New analytic methods offer children's hospitals an opportunity to recognize how organizational resilience promotes patient safety. Ideally, an organization achieves a balance in both system standardization and resiliency.

Resiliency analysis allows for reflection on performance variability, which leads to understanding how the system functions and how front-line staff make decisions to produce safer care. Organizational resilience is assessed for improvement opportunities in four areas: learning, responding, anticipating and monitoring. Participation and engagement with peer hospitals in the PSO supports children's hospitals' resiliency to eliminate preventable patient harm, which is the global aim.

CHILDREN'S HOSPITAL ASSOCIATION

The PSO's SMART aim

After several years contemplating how the PSO contributes to the global aim and how it can be measured, a new PSO SMART aim was introduced at the annual meeting.

All PSO children's hospitals have participated in case learning offered through Safe Tables, which is the core element of the SMART aim. Hospital-specific reports will provide more detail on ideal engagement, measurement and your organization's participation. Highly engaged organizations are those that participate in key value added activities within the PSO. We believe this aligns with organizational learning and resiliency. Today, 40% of children's hospitals are considered highly engaged. Our goal is for all children's hospitals in the PSO to be highly engaged by 2022, and providing a hospital-specific report is a first step as we assess what can increase engagement.

SMART AIM

By December 2022, 100% of member children's hospitals are highly engaged in Child Health PSO case learning to strengthen organizational resilience to eliminate harm.

Emerging themes in 2019

Case report themes are made actionable from patient safety team analysis of why safety events happen. Deeper understanding and involvement from subject matter experts promotes richer learning and development of alerts and safety tools. Children's hospitals report two emerging themes in the types of patient care vulnerabilities: medication safety and patient harm in surgical settings, both of which are being explored to identify how the PSO can help advance safety improvement.

Top causal themes (*figure 1*) addressed the past several years have led to an upcoming safety toolkit to uncover the pivotal points of communication in the diagnostic process. In analyzing these cases, the level of most serious harm (SSE 1-3) grows from 21% for all cases reported to the PSO to 60% for missed, delayed or wrong diagnosis and treatment when communication is a causal factor (*figure 2*).

As we celebrate children's hospitals' continued efforts to make progress individually, we are reminded of a growing imperative and opportunity for all children's hospitals to strengthen their resiliency profile. The opportunity to spare a child from experiencing serious preventable harm will continue to drive our shared purpose and commitment to case reporting and learning within the Child Health PSO.

Thank you to our participating children's hospitals, Board of Directors and Patient Safety Team, Solutions for Patient Safety and NextPlane Solutions, LLC.

EMERGING THEMES

Medication Safety and Patient Harm in Surgical Settings were in the top 3 event category types.

Fig. 1 | Causal Factors: Why Events Happened

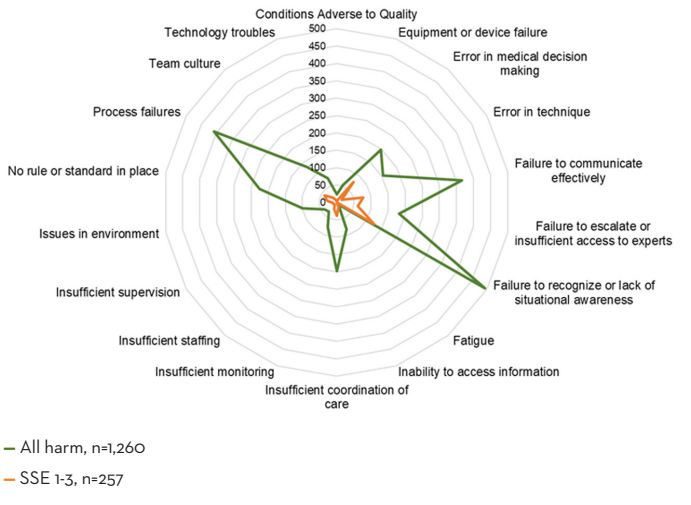
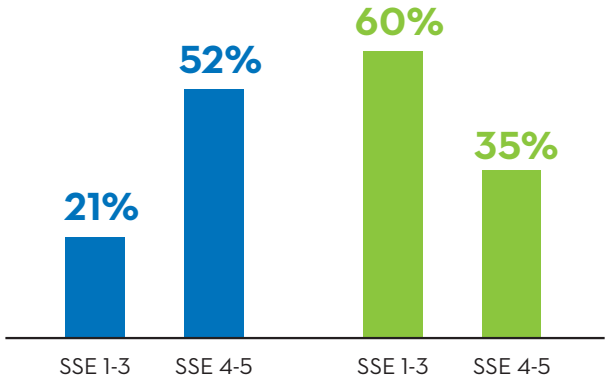


Fig. 2 | Serious Safety Events



[1] Hollnagel, E., Paries, J., Woods, D.D., and Wreathall, J. (Eds.) (2011), Resilience Engineering in Practice: A Guidebook; Epilogue: RAG - The Resilience Analysis Grid, page 275-296, Ashgate Publishing, Farnham, Surrey (UK)

To cite: Children's Hospital Association. 2019. "Building Resiliency."