Photo: Micheal Goderre, Boston Children's Hospital

Driving Safety Together

Child Health Patient Safety Organization®

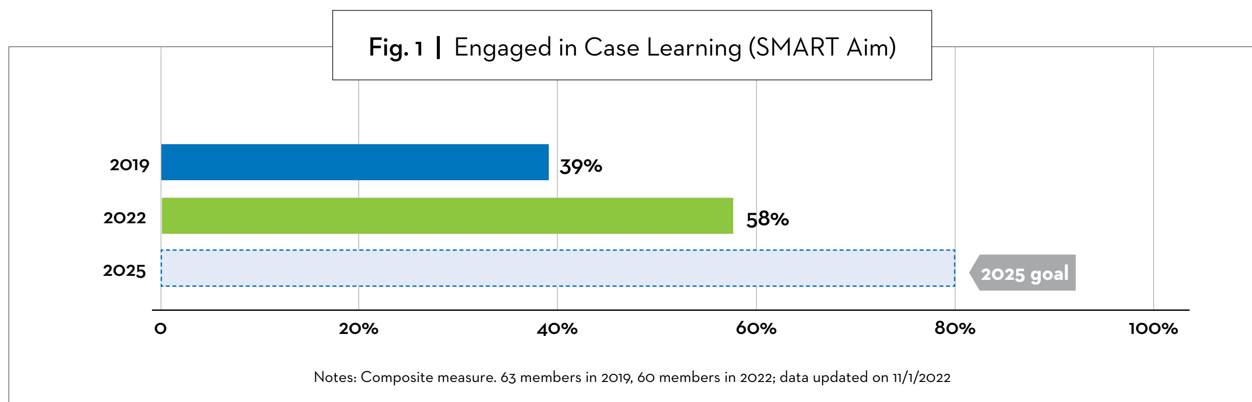
2022 ANNUAL REPORT

The Child Health Patient Safety Organization (PSO) is driven by a preoccupation with failure—we seek to help children's hospitals turn errors into improvements to prevent pediatric harm. Through our learning network, we provide a collaborative environment where member hospitals confidentially share their safety cases, discuss solutions, and work together to address the most pressing challenges they face in an uncertain world and health care environment.

High engagement in the PSO creates a relevant and sustainable learning safety network to achieve our global aim of eliminating preventable pediatric harm. We continue to strive toward our immediate goal to increase the number of engaged hospitals by 10%, with a long-term goal of 80% engagement by December 2025 (figure 1) as we work together to strengthen organizational resilience among our members.

Engagement in the PSO is one way hospitals ensure they understand and address the leading patient safety topics in the country. We prioritize learning themes from our top safety event categories (figures 2 and 3) identified through voluntarily reported cases and analysis of our monthly safe tables, weekly huddle discussions, alerts, annual meeting, and other offerings—meaning our learning network provides comprehensive, timely updates on the most relevant and important safety issues in children's hospitals.

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



Notes: Composite measure. 63 members in 2019, 60 members in 2022; data updated on 11/1/2022

CHILDREN'S HOSPITAL ASSOCIATION

In our weekly huddles, members share near real-time information on patient safety events, which enables members to stay up-to-date on the latest safety issues and quickly collaborate on solutions. Almost 40% of huddle reports are requests for help by colleagues, with the top request being evidence-based practices and procedures demonstrating their effectiveness in preventing harm.

One of this year's most impactful huddle discussions focused on nurturing psychological safety to reduce burnout, which helps drive patient safety. The annual meeting expanded on this topic, centering on workforce burnout, joy in work, and achieving psychological safety to address overwhelming stress and reconnect to what matters.

Generally, the themes in safety huddles are consistent with our top event categories, which include medication errors, diagnostic safety, and suboptimal care coordination. This year, we extended our medication event classification taxonomy to better understand the contributing factors to these events, and we began exploring issues related to electronic health records, such as medication reconciliation and alerts/triggers.

As we look to 2023 and beyond, we will continue to focus on medication and diagnostic safety, leveraging opportunities to learn and share within the PSO. But we will also provide new opportunities, enhancements, and solutions to meet the evolving needs of our members. We are adding self-assessments as a new engagement metric after each monthly safe table presentation to help organizations implement what they've learned. To enhance tailored support to individual hospitals, we are evaluating technology upgrades to collect better data and metrics that drive actionable engagement, tools and deliverables. We have begun exploring ambulatory care in addition to inpatient care, as there is much overlap of data. Additionally, part of our discussion will center on belonging, diversity, equity and inclusion. To do this, we will need support from our members.

The chance to spare a child from experiencing serious preventable harm will continue to drive our shared purpose within the PSO. We look forward to working with you to continue the learning system journey! Thank you for your efforts as part of the Child Health PSO, especially contributors to the safe tables, annual meetings, and, most importantly, case reporting. Thank you 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.

INTERVIEW

Children's Hospitals Today promoted the PSO's human trafficking alert through an interview with the medical director at the International Centre for Missing and Exploited Children.

IBY THE NUMBERS

60 member hospitals
2,895 early warnings
1,998 events analyzed
17 alerts
4 risk assessments

Fig. 2 | Top 3 Event Categories

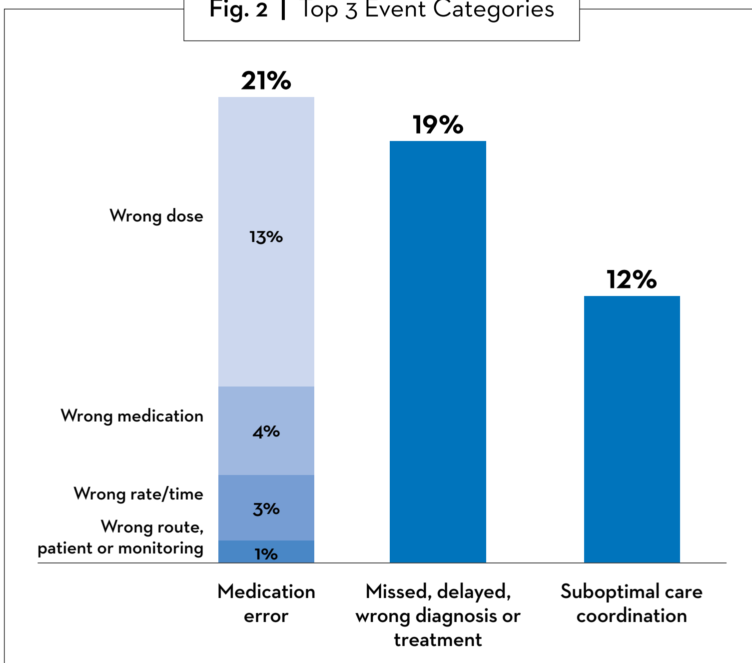


Fig. 3 | Top Event Causal Factors