Safety

Safety is our core value, and it includes both our patients and employees. Healthcare processes, technologies and team structures are complex, which creates a potential for errors. Similar to other complex industries (i.e., aviation, nuclear energy) we aim to use high-reliability principles to provide safe care. We build structures, processes, operational rules and culture to become a high-reliability organization.

High-Reliability Principles

- preoccupation with failure
- reluctance to simplify interpretations
- sensitivity to operations
- deference to expertise

Our Methodology

- focusing on outcomes of harm
- detecting harm
  - instilling a culture of open-ended conversation and self-reporting
  - utilizing Keepsafe reporting (a self-reporting system of all events related to safety and quality of care)
  - implementing unit safety huddles
  - rounding to influence
  - tracking and trending all safety reports
- measuring harm
  - Root Cause Analysis (RCA) of Serious Safety Events (SSE)
  - Apparent Cause Analysis (ACA) of precursor safety events and near misses
  - common cause analysis data from SSE, precursor safety events and near misses to identify themes and trends for improvement as an institution, and predict where harm will occur in the future
  - a significant events committee, chaired by Eduardo Perelstein, M.D. M.P.H., and
staffed by representatives from each clinical unit, both inpatient and ambulatory, meeting monthly to review all pediatric Keepsafe reports and safety events (serious safety events are analyzed using RCA, while precursor events and near misses are analyzed using ACA)

- **building a culture of safety**
  - partnering with patients and families through the Komansky Children’s Hospital Family Advisory Council and Teen Advisory Council
  - developing a safety coaching program using the “all teach, all learn” approach including staff who:
    - spread the reliable use of expected safety behaviors to reduce harm to patients, families, employees and visitors
    - teach and support their colleagues’ safe practices
    - encourage open communication about safety at all levels
    - identify and share safety improvement opportunities
    - build accountability

- **safety rounds** conducted weekly, led by chairs of the Department of Pediatrics and the Significant Events Committee, held on all units in the hospital where children receive care, and attended by unit staff (physicians, nurses, clerks, etc.), who are asked to provide information regarding safety concerns about the unit that could place patients at risk (identified problems are referred to our Pediatric Operations Committee - chaired by Bruce Greenwald, M.D., and attended by representatives from all functional units in the hospital – for solution identification)

- **mandatory error prevention training** using behavioral-based expectations for all staff

- **flattened hierarchies** in high-risk areas

- **simulation training**
  - administering, analyzing and taking actions based on our annual AHRQ patient safety survey to improve our results and keep patients and employees safe