Photo: Juan Pulido, Children's Medical Center Dallas

Adapting Together for Safety

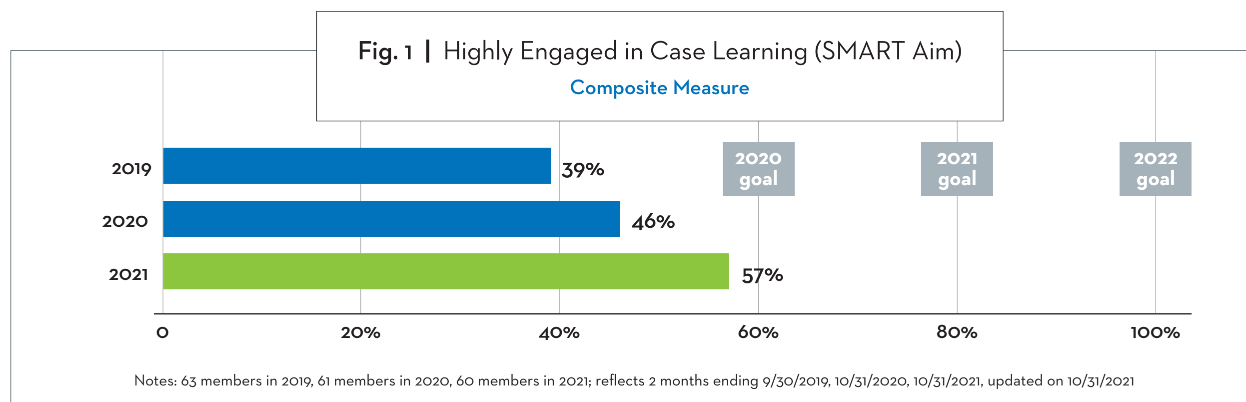
Child Health Patient Safety Organization®

2021 ANNUAL REPORT

The Child Health Patient Safety Organization (PSO) is built on collaboration to achieve better, safer, and more reliable patient care in children's hospitals. Children's hospitals have become safer, more resilient organizations by accelerating improvement in patient safety through shared learning and proactively assessing and mitigating preventable harm.

This year, we invited members to share how the PSO can best support being safer together. Sixty-two percent of the membership participated in providing feedback. Responses were highly encouraging on the PSOs alignment with organizational progress in patient safety. Half of the PSO membership participates in case learning and huddles which enabled clarifications on the types of reporting that are beneficial and training opportunities for new hospital staff. This year, 57% of members were highly engaged in the PSO and there was an 11% improvement in overall case learning (*figure 1*). This measure reflects 68% of children's hospitals submitting two or

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



Notes: 63 members in 2019, 61 members in 2020, 60 members in 2021; reflects 2 months ending 9/30/2019, 10/31/2020, 10/31/2021, updated on 10/31/2021

CHILDREN'S HOSPITAL ASSOCIATION

more cases over the last year. It also includes more than a 10% increase in Safe Table attendance—which demonstrates high levels of engagement. For members that participate in weekly Safety Huddles, they are asked to attend at least 80% of the sessions, which serve as the PSO's early warning system. This year, 71% of children's hospitals achieved this, a 6% increase from 2020. It is remarkable to see an increase in engagement considering the pandemic.

Through voluntarily reported cases and analysis, the patient safety team has prioritized diagnostic safety, failure to recognize and communication failures over the last several years (*figures 2 and 3*). These themes were apparent in the child trafficking alert that focused on how to develop a health care protocol identifying trafficked and exploited children.

The themes for this year's annual meeting were complexity science and safety-II adapting together to accelerate safety. Content was aimed around building resilient teams using the Team of Teams concept and focusing on high-reliability and volatility, uncertainty, complexity, and ambiguity principles. Participants learned from frontline staff to better understand adaptive thinking and the role of psychological safety, collaboration, accountability, and leadership. Updates on the Patient Safety Act and its application were also provided.

We celebrate two recent publications recognizing the value of the PSO and the children's hospital leaders who are improving the safety and quality of pediatric health care delivery using the PSO network. The Child Health PSO at 10 Years: An Emerging Learning Network was published in *Pediatric Quality and Safety*. Factors Related to Serious Safety Events in a Children's Hospital Patient Safety Collaborative was published in *Pediatrics*.

Together, we are adapting to this ever-changing world and hitting new milestones in safety. The opportunity to spare a child from experiencing serious preventable harm will continue to drive our shared purpose within the PSO. As we look to 2022, we will explore medication safety, and encourage you to continue leveraging opportunities to learn and share within the PSO.

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

MONTHLY LEARNING

Members recognized the addition of continuing education credit for Safe Tables as a benefit of participation.

SAFETY TOOLKIT

The Diagnostic Safety Toolkit released in May 2020 has now reached over 55 children's hospitals in the PSO and 27 organizations in 19 countries.