CHILDREN'S HOSPITAL ASSOCIATION

Child Health
Patient Safety Organization®

The Journey to Zero

2024 ANNUAL REPORT

The Child Health Patient Safety Organization (PSO) exists to help children's hospitals achieve a shared goal: eliminating preventable harm. As the only PSO in the nation dedicated exclusively to children's hospitals, we offer unique opportunities to confidentially explore harm in pediatric settings through shared learning, including monthly safe tables, weekly huddles, safety alerts, an annual conference, and more.

Through these learning engagements and the dedicated work of nearly 60 member hospitals, we develop crucial resources to advance patient safety across the industry and timely tools to equip our members in their hospitals. In 2024, we celebrated several learning and development improvements designed to advance patient safety.

Enhanced data tracking and sharing

Our most significant accomplishment was migrating data sharing capabilities to a new vendor, Riskonnect. The new platform enhances member support by:

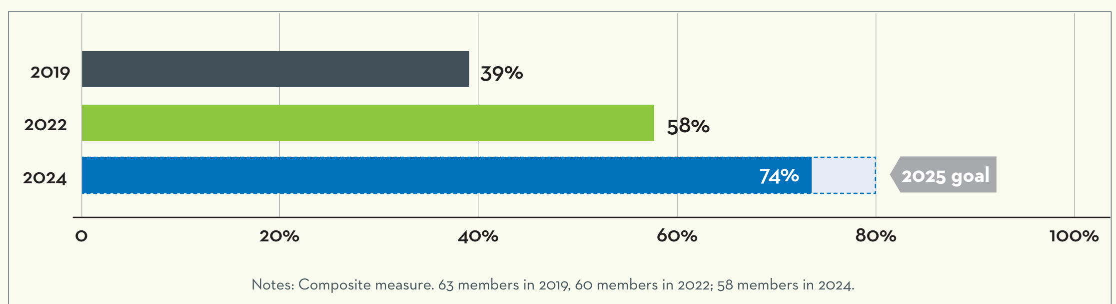
- **Improving data collection** through the expansion of demographic, diagnostic, and high-reliability metrics.
- **Enriching member resources** by scoring action plans and establishing best practices viewable as deidentified corrective actions.
- **Improving huddle analysis** by housing all weekly PSO huddle report submissions on a single platform.
- **Empowering safety improvements** with on-demand access to proactive mitigation strategies.
- **Strengthening learning opportunities** by automating and improving analysis and reporting capabilities.

Using the Riskonnect data analytics is a great time saver and is helping our hospital share our data in a more meaningful way.

—Stephanie Hager, Norton Children's Hospital

Smart-Aim Engagement

The more hospitals engage, the more we improve. That's why we set an ambitious goal of 80% engagement from members, and we're almost there.



Notes: Composite measure. 63 members in 2019, 60 members in 2022; 58 members in 2024.

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Replicable action plans

Thanks to the robust reporting opportunities within Riskonnect, members can access a deep and diverse repository of action plans, which outline a hospital's specific actions to prevent a safety event from recurring. Members can quickly and easily search other hospitals' plans ranked by effectiveness and by event category (e.g., medication errors). Details are deidentified and action items are modified to make them applicable to multiple members. "My favorite new feature is the action plan repository. Our hospital safety team can view action plans organized into different processes as a reference," said Amanda Carver, Cincinnati Children's Hospital.

"I like having access to the Action Plan Repository that provides action item reliability strength and examples of detailed action items that came from actual work in member organizations," said Kerri Kuntz, Children's Mercy Kansas City.

Timely guidance

Several national proposals emerged affecting patient safety, including a report from the President's Council of Advisors on Science and Technology (PCAST) seeking a "nationwide transformational initiative" in patient safety, a CMS rule, and proposed national safety board legislation, among others. To help members navigate these complex issues, we created a comprehensive guide and hosted a panel discussion at our Annual Meeting with the PCAST report's authors. We are committed to providing you with crucial and timely guidance during a changing and uncertain patient landscape.

2024 By the Numbers

42 safety huddles

13 safe tables

298 annual meeting attendees

Industry leadership

In collaboration with the CHA quality improvement team, we launched a pilot study in April to understand the feasibility and impact of the Child Health PSO Diagnostic Safety Toolkit. The study's abstract won Best Abstract for Applied Innovation at the 2024 Diagnostic Excellence Conference. We'll share findings in 2025. This is only the beginning of many quality improvement opportunities we're exploring in diagnostic safety.

Throughout 2024, we actively worked with our members to develop a paper describing trends from our most valued deliverable in the PSO, the multi-center weekly safety huddle. We expect it to be published in early 2025.

Additionally, our team presented at EPIC's Kid Share roundtable, highlighting our practical framework for capturing health IT data. This is part of our team's in-depth exploration of medication errors related to electronic health records and health information technology. We aim to publish our findings in 2025.

The journey continued

As we look ahead, sparing children from serious preventable harm will continue to drive our shared purpose. We will evolve to ensure children's hospitals have the right tools to improve patient safety while building upon established partnerships.

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 depend on your participation. We look forward to continuing the learning network journey together in the coming year!

2025 Look-Ahead | New member and industry resources coming soon

Safety Watch

Recurring notifications highlighting timely safety issues.

Safety Huddle Publication

A new paper discussing a learning system to promote situational awareness.

EHR Guidance

Actionable recommendations for medication errors involving EHRs and HIT.

Safety Action Plan

Easy-to-apply action plans synthesizing the strongest plans.