Ohio Children's Hospitals' Solutions for Patient Safety
Every patient. Every day.

December 2012

OCHSPS National Children's Network 2012 Year in Review

Transforming the Safety and Quality of Care in Pediatric Hospitals

The OCHSPS National Children's Network represents the most herculean effort to date by the country's children's hospitals to create a universally safe and healing environment for all children who are in our care. With the creation of the OCHSPS National Children's Network, made possible by the federal *Partnership for Patients* initiative, children's hospital leaders from across the U.S. have stepped forward and committed to clear, shared goals of harm reduction. The network, which includes 33 hospitals currently and will expand to become a network of 83 children's hospitals in 2013, seeks to achieve following goals by December 31, 2013:

- 40 percent reduction in hospital-acquired conditions
- 20 percent reduction in readmissions
- 25 percent reduction in serious safety events (SSEs)

To achieve these goals, CEOs, hospital boards of trustees and clinical leaders are aligning organizational goals with the network harm reduction goals in a way that will truly transform the safety and quality of care delivered in children's hospitals in the United States.

National Commitment to Across-the-Board Harm Reduction

During 2012, 33 leading children's hospitals established a nationwide commitment to safety. They have agreed NOT to compete on safety. Instead, the focus of the network is to share successes and failures transparently to improve safety in all children's hospitals across the country. In addition, during its first year, the network:

- **Built a robust pediatric improvement network to drive and support improvement:** We have built a robust national network that includes a data collection and analysis infrastructure; frequent opportunities to share and learn from high performers in the network; and a strong CEO leadership group to remove barriers to success and advise on strategic direction. We are already beginning to see reductions in some of the hospital-acquired conditions. Examples include falls and surgical site infections.
- **Established shared harm reduction goals:** We established baselines and reduction goals for nine hospital acquired conditions (HACs) and readmissions.
- **Began national implementation of safety leadership practices:** Network CEOs committed to and began implementing the Daily Organizational Safety Brief – a deliberate, focused report and conversation among leaders about safety events and safety risks. During these daily briefings, leaders look back on significant safety or quality issues from the last 24 hours; look ahead to anticipated safety or quality issues in next 24 hours; and follow-up to provide status reports on issues identified.
- **Developed pediatric-specific measures:** Network hospitals developed and agreed to specific pediatric measures for nine HACs and readmissions. The definitions and standard approaches being established by the network have the potential to become the standard for all of pediatrics.

Phase I Participating Hospitals

- Akron Children's Hospital
- Arkansas Children's Hospital
- Children's Healthcare of Atlanta
- Children's Hospital at Vanderbilt
- Children's Hospital Boston
- Children's Hospital Colorado
- Children's Hospital Los Angeles
- Children's Hospital of Philadelphia
- Children's Hospital of Pittsburgh
- Children's Hospital of Wisconsin
- Children's Hospitals and Clinics of Minnesota
- Children's Mercy Hospitals and Clinics
- Children's National Medical Center
- Cincinnati Children's Hospital Medical Center
- Cleveland Clinic Children's Hospital
- Cook Children's Medical Center
- Dayton Children's Hospital
- Helen DeVos Children's Hospital
- Intermountain - Primary Children's Medical Center
- Cohen Children's Medical Center of New York
- Lucile Packard Children's Hospital
- Mercy Children's Hospital
- Nationwide Children's Hospital
- Nemours - Alfred I. duPont Hospital for Children
- ProMedica Toledo Children's Hospital
- Rady Children's Hospital
- Rainbow Babies & Children's Hospital
- Riley Hospital for Children at Indiana University Health
- Seattle Children's Hospital
- St. Louis Children's Hospital
- Texas Children's Hospital
- University of Michigan C.S. Mott Children's Hospital
- Wake Forest Baptist Health - Brenner Children's Hospital

"The opportunity to participate in OCHSPS has been a tremendous boost…accelerating, focusing and broadening our work on preventable harm. Doing 10 collaboratives at once would not have been thinkable in the past but we are pulling it off… This work is phenomenal. We have the right leaders and hospitals from the nation's best children's hospitals all working together to reduce harm to kids. It's an easy mission to believe in and to work towards." – Dan Hyman, MD, MMM – Chief Quality Officer, Children's Hospital Colorado

Eliminating Serious Safety Events and Creating a Culture of Safety

Focusing on the elimination of Serious Safety Events (SSEs) is a natural next step in our quest to eliminate all harm at pediatric hospitals across the country. In order to eliminate SSEs, hospital leaders must commit personal leadership, hospital staff and resources to drive a culture of safety within their institutions. Both our learning about the causes of SSEs and the safety culture created through this work will inevitably lead to a reduction in *all* harm in the nation's children's hospitals – as many of the causes of SSEs also contribute to other incidents of harm.

This year, the network:

- **Launched SSE and culture transformation training for certain Phase I hospitals:** Phase I hospitals committed to go beyond HAC reduction goals to also focus on SSE reduction and cultural transformation together. Hospitals within the network have begun to employ the cultural strategies of other high reliability industries to significantly reduce the incidence of SSEs and other elements of harm. In November, a select group of Phase I hospitals began this journey with training on the SSE classification system and learning how to calculate their organization's SSE rate. The remaining Phase I hospitals will begin this journey in May 2013.
- **Established partnership with a patient safety organization (PSO):** The network formalized a partnership with the Child Health Patient Safety Organization (PSO) to facilitate rapid sharing and learning related to Serious Safety Events (SSEs).

Since 2011, Ohio children's hospitals have been employing the strategies of other high reliability industries – such as aviation and nuclear power – that achieve high levels of safety in the face of considerable hazards and operational complexity – to reduce SSEs across the state. For example, every one of the 30,000 employees in Ohio's children's hospitals receives training on expected behaviors to help prevent errors whether they are a CEO, clinician, administrative support or janitorial staff. We know these methods make a difference: Ohio children's hospitals have already reduced the incidence of SSEs by 50 percent.

More information about the Network and its work can be found at *www.SolutionsForPatientSafety.org*

All Teach, All Learn

OCHSPS is committed to an "All Teach, All Learn" approach, in which network members must humbly share and gratefully learn from others. Accomplishing our goals requires:

- Focus on the detailed processes and cultural elements that lead to safer hospitals;
- Guidance and support for hospital teams as they build the capacity for change; and
- Facilitating relationships within the network to broaden and accelerate learning.

Executive leadership is a critical aspect of successful improvement in pediatric patient safety. With our goals in mind, we have designed a number of efforts to inspire and continuously develop the safety leadership skills of the executives who lead our network hospitals, including the following:

- Monthly CEO updates via a dashboard and run charts on each HAC.
- Quarterly CEO webinars to share network progress, alert leaders to challenges and identify opportunities to overcome barriers.

Additionally, in 2013, through the Cardinal Health Leadership Development Program, network hospitals will have access to safety governance seminars to further their board's ability to support quality and safety as a top institutional priority. Seminars will include, in partnership with IHI, offerings of the foundational "Boards on Board" program and an advanced board seminar currently under development.

"The focus areas of the collaborative have allowed us to increase alignment of effort and purpose among the Departments of Infection Prevention, Quality, Safety, Nursing, and the Medical Staff. We have appreciated the discipline required to report our outcomes and bundle compliance according to standard definitions. We have seen an increase in organizational transparency and engagement in quality improvement at all levels." – Rob Payne, MD – Medical Director of Quality, Children's Hospitals and Clinics of Minnesota