On The Road to Zero Harm: Implementation of The Life Cycle of a Safety Event

THE UNIVERSITY OF CHICAGO UChicago Medicine | Center for Healthcare Delivery Science and Innovation

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AT THE FOREFRONT OF KIDS MEDICINE UChicago Medicine Comer Children's

Problem

Problem:

- Lack of global awareness of safety events occurring within the Children's Hospital.
- Lack of structured communication & escalation of safety concerns.
- Poor follow up to reporters regarding outcomes or process improvements made in response to submitted reports.

Opportunity:

- Transparency and communication of process improvements with front line caregivers demonstrates our commitment to patient safety and encourages staff engagement, ultimately leading to better patient care and outcomes.
- This project demonstrates a structured approach to address safety concerns with the ultimate goal to improve patient outcomes.
- It supports the goals outlined within the Quality & Safety Pillar of the Pediatric & Perinatal AOP for FY24.

Goal

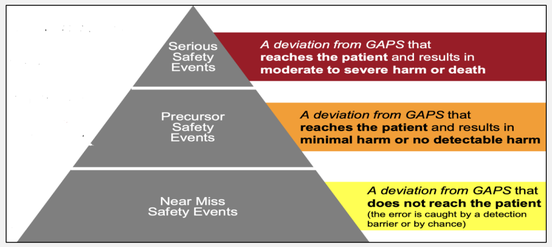
- To create a culture of safety within the Children's Hospital focused on enhancing the process for real time identification, escalation, action, and feedback of process changes to teams.
  - Escalation: 75% of all event reports submitted to Riskonnect will be also be reported in tier 1 or 2 huddles by 12/1/23.
  - Feedback: Develop and share lessons learned within 8 weeks of identification for all safety events that trigger an Apparent Cause Analysis (ACA) by 1/1/24.

Strategy

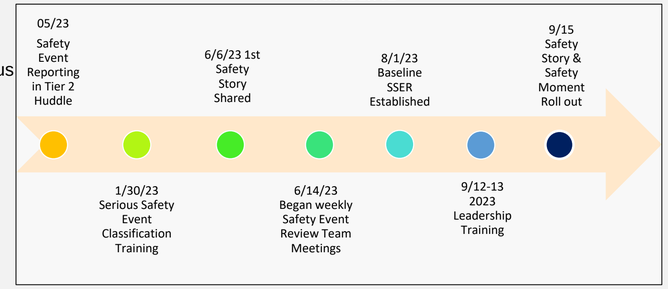
- Establish a Comer Safety Oversight Team
  - Determine baseline Serious Safety Event Rate (SSER)
  - Weekly Review Serious Safety Events (SSE)
- Utilize the concepts of high-reliability and the Press Ganey Serious Safety Event Classification and taxonomy tools.
- Develop and modify tools to supplement event tracking:
  - Redcap Initial Event Entry
  - Apparent Cause Analysis (ACA) Redcap
  - Action Plan and Follow-up Template
  - Lessons Learned Template
  - Safety Story submission & sharing
- Workflow process was socialized with frontline leaders

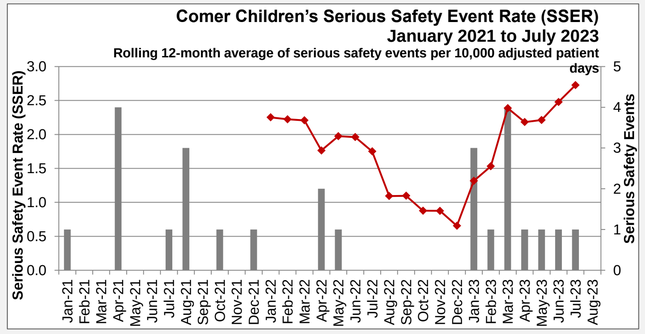
Measures of Success:

- Increased number of events in event reporting system
- Higher percentage of events escalated in Tier 1,2 huddles
- Decreased Serious Safety Event Rate (SSER)



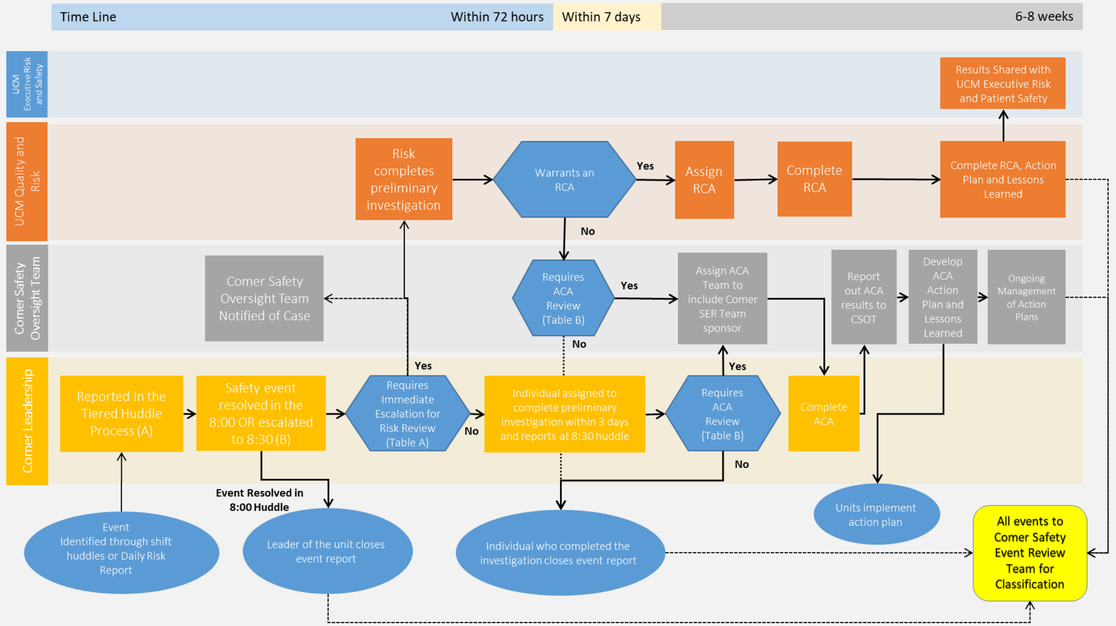
TIMELINE





Impact

LIFECYCLE OF A SAFETY EVENT



- Partnership with Risk & Patient Safety
- 84 Events reviewed retrospectively by Comer Safety Oversight Team to determine baseline SSER

Next Steps

- Working with marketing to develop a personalized zero harm logo for Children's Hospital
- Providing Leadership Methods Training to Leaders within Children's Hospital on Culture of Safety
- Sharing of safety stories with all staff
- Development & implementation of culture of safety training for all staff
- Implementation of safety coaches

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