4.14 PATIENT SAFETY

Introduction

Patient safety is defined as freedom from accidental injury caused by medical care, such as harm or death attributable to adverse drug events, patient misidentifications, or health care-acquired infections. In 1999 the Institute of Medicine (IOM; now the National Academy of Medicine) published the "To Err is Human" report, which challenged United States healthcare systems and providers to recognize, report, and mitigate error and harm to patients. Children, as a vulnerable population, are at particular risk for medical errors and specifically medication errors. Pediatric hospitalists work in the acute care hospital setting where high-risk diagnostic decision-making, transitions of care, medication safety, and handoffs are commonly performed. Pediatric hospitalists therefore have a duty to promote patient safety and help develop and implement systems to reduce both error and harm to hospitalized children.

Knowledge

Pediatric hospitalists should be able to:

- Review the basic principles of patient safety, including systems redesign and the prevention, identification, and mitigation of preventable adverse events.
- Review the difference between error and harm including different types of errors.
- Cite the key components of a culture of safety.
- Review the fundamental components of a "Just Culture" and describe how organizations can achieve them.
- Discuss why errors are multifactorial and more often the result of systems failures rather than individual failures.
- Define the concept of "second victim" and review steps to support colleagues, trainees, and other providers when they become a second victim.
- Define common features of a "High Reliability Organization" and explain how high reliability principles apply to clinical care and work on patient safety initiatives.
- Review common patient safety interventions to reduce errors, including electronic order sets, practice guidelines, checklists, clinical decision support, double checks, bar coding, lock-out drawers, and others.
- Discuss factors unique to children that lead to increased risk for medication errors.
- Describe how using structured communication techniques, such as standardized handoffs, closed loop communication, active listening, and critical language are critical to safety.
- Describe the role of patient/family engagement in patient safety.
- Describe the safety components of hospital accreditation and how pediatric hospitalists can help ensure these standards are met.
- Describe common types of cognitive biases, such as premature closure, anchoring, and others, and review how they contribute to diagnostic error.
- Discuss the goals of national safety collaboratives, such as Solutions for Patient Safety (SPS) and describe safety bundles for common hospital-acquired conditions (HACs).
- Review the role of pediatric hospitalists in maintaining national safety goals required by common key accrediting organizations, such as The Joint Commission (TJC) and others.

Skills

Pediatric hospitalists should be able to:

- Demonstrate skill in creating an environment that reflects a high reliability organization.
- Facilitate safe and efficient hospital admissions and discharges.
- Identify and order the level of nursing care needed for safe patient care.
- Engage and educate patients and the family/caregivers on their role in ensuring patient safety.
- Utilize and participate in optimizing patient safety features of health information technology.
- Educate trainees, colleagues, and other healthcare providers on basic safety principles.
- Demonstrate proficiency in reporting errors using safety reporting systems.
- Work effectively and collaboratively with patient safety teams.
- Engage in patient safety event reviews, including (root) causal analyses, Morbidity and Mortality committees, and sentinel event reviews.
- Disclose medical errors clearly, concisely, and completely to patients and the family/caregivers.
- Participate in continuous readiness for accreditation agencies by consistently adhering to patient safety practices.

Attitudes

Pediatric hospitalists should be able to:

- Reflect on the importance of creating and sustaining a culture of patient safety.
- Role model behaviors that exemplify a "Just Culture," accountability, and learning from failure.
- Recognize that patient safety improvements come from consistently reporting near misses as well as medical errors.
- Promote an awareness of the need for and will for change to make patient safety a high and consistent priority.

Systems Organization and Improvement

In order to improve efficiency and quality within their organizations, pediatric hospitalists should:

- Lead, coordinate, or participate in multidisciplinary broad strategies to positively impact patient safety in the organization.
- Collaborate with hospital administration and community leaders for the necessary information systems and other infrastructure to ensure success with pediatric patient safety initiatives.
- Lead, coordinate, or participate in multidisciplinary initiatives to develop and implement patient safety interventions where possible.

- Actively participate in hospital-wide safety committees and seek to become leaders in pediatric patient safety in their institutions.

References

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2. Muething SE, Goudie A, Schoettker PJ, et al. Quality improvement initiative to reduce serious safety events and improve patient safety culture. *Pediatrics*. 2012;130(2): e423-e431. https://pediatrics.aappublications.org/content/130/2/e423.long. Accessed August 28, 2019.
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