# PATIENT SAFETY

## INTRODUCTION

The topic of Patient Safety became a major priority for healthcare providers in 1999 when the Institute of Medicine (IOM) report entitled "To Err is Human" focused attention on patient safety and medical errors. The Institute of Medicine defined safety as "freedom from accidental injury" and error as the "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim". The IOM report estimated that between 44,000 to 98,000 Americans die each year as a result of medical errors which exceed the number attributable to the 8th leading cause of death in America. Total national costs of preventable adverse events are estimated to be up to $29 billion. Since the initial publication of the 1999 IOM report, there have been a number of local, state, and national programs focused on reducing error. Efforts over the past few years have attempted to better classify errors by the harm caused, allowing targeted interventions to specifically address these more clinically significant events. Children, as a vulnerable population, are at particular risk for medical errors and specifically medication errors. Pediatric hospitalists have an exceptional opportunity to promote patient safety and help develop systems that will reduce harm in the inpatient arena.

## KNOWLEDGE

*Pediatric hospitalists should be able to:*

- Identify the basic principles of patient safety as outlined in the original 1999 IOM report.
- Describe the culture necessary for successful safety efforts. Define "Just" culture.
- Define commonly used terms and tools of Patient Safety such as reliability, transparency, adverse medical event, harm, preventable errors, failure mode effects analysis (FMEA), root cause analysis (RCA) and trigger tool.
- Name common patient safety practices and enhancements including pre-printed order sets, practice guidelines, electronic health information systems, bar coding, time-outs, and others. Explain how new errors can be associated with the introduction of these enhancements.
- Discuss why errors are more often a result of systems failures rather than individual failures.
- Explain how decreasing unwanted variability in care impacts patient safety.
- Illustrate that building safety into everyday processes of care is the most effective way to reduce or prevent errors.
- Describe how patient safety is threatened by poor information transfer and failed communication.
- Discuss strategies for effective, efficient, and safe communications that impact all aspects of patient care such as handoffs between healthcare providers, team rounds, family engagement, and others. List the strengths and limitations of different communication methods.
- Describe the effects of sleep quality and quantity on healthcare providers and the impact on patient safety.
- Summarize the components of family centered care and discuss the importance of engaging patients and the family/caregiver in safety efforts.
- Define the role of the Joint Commission (TJC) in hospital accreditation and describe how pediatric hospitalists can help assure relevant standards are met.
- Articulate TJC guidelines on patient safety and the National Patient Safety Goals.
- Discuss factors unique to children that lead to increased risk for medication errors, attending to weight-based dosing, developmental physiology, compounding and drug delivery methods, and others.
- Discuss how financial reimbursement from private and government payers can be tied to preventable patient safety events.
- List the common national societies and agencies [such as the Institute for Healthcare Improvement (IHI), American Academy of Pediatrics (AAP), TJC, Centers for Medicare and Medicaid Services (CMS)] influencing inpatient pediatric safety measures and describe pediatric hospitalists' role in responding to their statements.
- Delineate the role of pediatric hospitalists in assuring proper supervision of trainees and the impact of this on patient safety.

## SKILLS

*Pediatric hospitalists should be able to:*

- Arrange safe and efficient hospital admissions and discharges, addressing issues such as level of nursing care needed and coordination of care, respectively.

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- Proactively identify sources of potential patient harm, including environmental and personal factors that affect your ability to render safe medical care. Develop a plan to address appropriate negative influences.
- Consistently adhere to patient safety principles when providing direct patient care such as when ordering treatment, performing procedures, and communicating care plans.
- Set performance standards and expectations for patient safety in the hospital setting.
- Educate trainees, nursing staff, ancillary staff and peers on basic safety principles.
- Demonstrate proficiency in using the institution's safety reporting system.
- Work effectively and collaboratively with safety teams, utilizing safety tools including reduction of process complexity, building in redundancy, improving team functioning and identifying team members' assumptions.
- Implement and serve as a physician champion for patient safety initiatives that protect children from harm.
- Actively contribute during ad hoc and sentinel event reviews.
- Disclose medical errors clearly, concisely and completely to patients and/or caregivers.

### ATTITUDES

*Pediatric hospitalists should be able to*:

- Seek opportunities to be involved in strategies to eliminate harm.
- Role model effective infection control practices in daily patient care activities.
- Build an awareness of the need for and will for change to make patient safety a high and consistent priority.
- Model behavior and take initiative in reporting medical errors.
- Work collaboratively to help create an open culture of safety within the institution.

### SYSTEMS ORGANIZATION AND IMPROVEMENT

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

- Engage the hospital senior management, the hospital board of directors and the medical staff leadership in making patient safety one of the top strategic priorities for the institution.
- Advocate for the necessary information systems and other infrastructure to secure accurate data and assure success with safety initiatives.
- Participate on patient safety committees at the group or systems level and seek opportunities to serve as medical safety officers or medical safety consultants locally or nationally.

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