Children's Hospital and Clinics

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Julie Morath came to Children's Hospital with a plethora of knowledge and enthusiasm regarding the implementation of a Patient Safety Initiative. Morth had three major goals for this project. First, she wanted to transform the organizational culture to provide an environment conducive to discussing medical accidents in a constructive manner. (Edmondson, Roberto, & Tucker, 2001, p. 6) The fact that she used the word " accidents" versus errors was significant. The terminology used to describe an adverse medical event needed to be changed. This along with blameless reporting changed the way the staff viewed and reported events. The goal was to figure out what happened, why it happened and how to prevent it from happening again. Forums and Focus groups were set up; this encouraged reporting of events, since the overall tone was to improve patient safety and not to blame. Descriptive safety reports allowed for a more vivid explanation of the issues rather than just checking boxes for JACHO compliance. The essence was to really evaluate the system breakdown.

The second initiative was to develop an infrastructure to implement safety improvements. Although the development of the infrastructure was successful, the implementation has been less than effective. The Patient Safety Steering Committee (PSSC) was responsible for setting the goals for the safety initiative and revising hospital policy and procedures. Focus analysis groups were developed along with new, more descriptive safety reporting forms. The intent again is to figure out what happened and fix the system. An additional component of this initiative included disclosure of medical accidents to the families as soon as possible after they occur. Although it appears the infrastructure is in place, the execution is not where is should be. Members of the PSSC committee felt there are not enough resources available to follow up and evaluate its findings from the focus analysis groups. They are lacking in the systems that reveal follow up on recommendations and measures to evaluate improvements. The team is frustrated and feels they are not accomplishing enough. A concern is they have become too large to be effective. The family notification has many physician and legal advisors very concerned it will promote litigation. There are no measures in place to evaluate the cost of these recommendations.

Finally, the third initiative was to overhaul the medication system. The plan was a good one, having the head of Pharmacy lead the effort. In order to make this successful he would evaluate the system from start to finish; physicians' order all the way to administration of the medication. This was key since many systems often fail between departments. Front line worker's developed Safety Action Teams in their units, they became so successful it spread to every unit. These teams aided in removing barriers and encouraging detection of potential errors with the " good catch" logs. These logs allowed the nurses to reveal areas they saw as potential problems. The teams felt empowered especially when they saw their efforts effect change as seen in the Kangaroo feeding bags. Although all of these efforts are commendable, we do not see any information regarding improved outcomes resulting from these efforts; where are the tangible goals?

As a board member, I feel that the program is important, yet I want to see data on the effectiveness of the program. Are we improving our operations in light of the IOM aims to improve patient safety? How have the programs we have implemented improved timely effective, efficient patient centered care? In addition, what is the timeline for these measurable goals?

I feel that the Informatics effort in this institution may have contributed to the error in Michael's medication dosage, The pharmacies intent was good, having a detailed label on the IV

bag with relevant information, yet it did not take into account what happens next in the chain prior to administration of the medication. This exemplifies the importance of systems being in place throughout the institution.

Intravenous medication errors are often the most serious and potentially fatal adverse events that occur in a hospital. There are ways Informatics could have helped to prevent these unfortunate events. First of all these labels should be sized to the devices that will deliver the medication. With the capabilities of computers and the knowledge of informatics we need to develop innovative ways to ensure systems that are full proof. Medical devices including infusion pumps are used throughout the hospital. We need to link the information in the patient's record, such as patient's weight, which is used to titrate medications, with the medical device. We need to work with the medical device companies to integrate safety features by bridging the gap from the order to the administration, whether it is a medication or procedure.

References

Edmondson, A., Roberto, M. A., & Tucker, A. (2001). Children’s Hospital and Clinics (A) [].

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