

Preventable harm in pediatric hospital care is estimated to occur in 1 of every 25 hospital admissions. Our goal is to bring that down to zero.

Alberta Children's Hospital (ACH) and Stollery Children's Hospital (SCH) have joined the Solutions for Patient Safety (SPS) Network, a network of over 140 children's hospitals across North America working together to eliminate serious harm for all pediatric patients.

Under the AHS program name Safest Together, the two Albertan children's hospitals will be working together to adopt evidence-based practices that have been shown to reduce hospital acquired harm. Achieving this goal will involve leadership, frontline staff, patients and families in improving our systems.

Targeting preventable harm

Implementation of validated care bundles to prevent Hospital Acquired Conditions (HACs)

ACH FIRST FOUR HAC TARGETS



Peripheral IV infiltrations and extravasations (PIVIE)



Pressure injuries (PI)



Central line-associated blood stream infections (CLABSI)



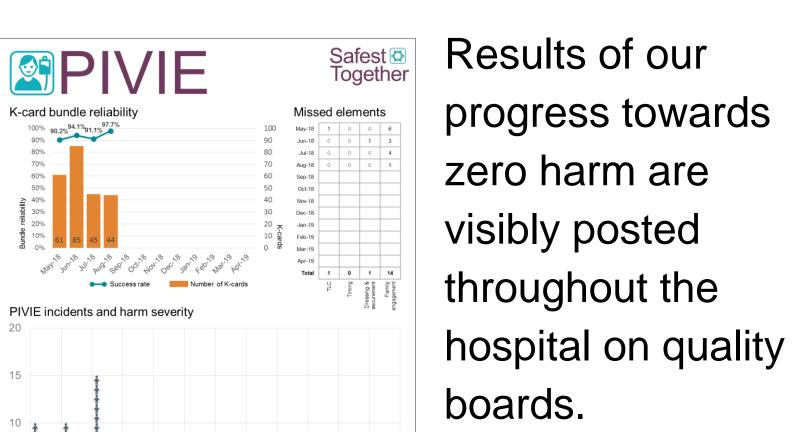
Surgical site infections (SSI)

KAMISHIBAI CARDS (K-cards)

Care bundle implementation is tracked using the K-card method. Peer-to-peer audits are conducted the nana fortop or nana PIV Look: Did the nurse inspectithe PIV site and dependent surfaces of the extremity? Compare: Did the nurse compare the extremities side by side? to ensure all elements of the bundle are reliably being performed.

PIVIE K-card

Least topological and the second seco



Culture Wave

Becoming a High Reliability Organization is an AHS priority. ACH and SCH are implementing error prevention training for all employees, physicians and volunteers to orient to a 'culture wave' of patient safety:

- Adopting safety culture principles into everyday practice
- Awareness of how humans make errors
- Use of error prevention tools
- Application of error prevention tools in practice
- Reinforcement and building of accountability for safety
- Seeking out and learning from 'good catches'
- Leadership methods to support, sustain and model error prevention tools and safety culture at the front line
- Focus on patient and staff safety



Serious Safety Events (SSEs) occur when we deviate from standard care and cause significant patient harm or death. SSEs are preventable, and examples include:

Safes oget	st 🐼 ther	BEHAVIOURAL EXPECTATIONS	TOOLS
EHAVIOURAL KPECTATIONS	TOOLS	Everyone maintains a questioning	Stop and Resolve Don't proceed in the face of uncertainty. Review your plan Resolve the concern Reassess your actions
veryone makes personal ommitment to afety	Introduce yourself with NOD Name – Occupation – Duty	attitude	
	Cross-Check Identify potential problems and seek advice from a team member.		QVV Qualify the source Validate the content
	ARCC Ask a question Request a change Concern – voice your concern Chain of command	Everyone communicates clearly	Verify your action Closed-Loop Communication Sender communicates information Receiver repeats back to sender Sender acknowledges accuracy,
veryone pays tention to etail	Self-check using STAR Stop – focus on the task at hand Think – plan your actions Act – carry out the planned task Review – verify the results	Safe	clarifies if necessary
Alberta Health Services	STOLERY CHURRENS CHURRENS CHURRENS Children's Hospital	belongs to a	all of us

Lanyard card – error prevention tools

FUTURE HAC TARGETS INCLUDE:

- Adverse drug events
- Catheter-associated urinary tract infections -
- Injuries from falls and immobility ELN.
- Ventilator-associated events
- Venous thromboembolism
- Unplanned extubations
- C. difficile and antimicrobial stewardship
- Nephrotoxic acute kidney injury - Cara

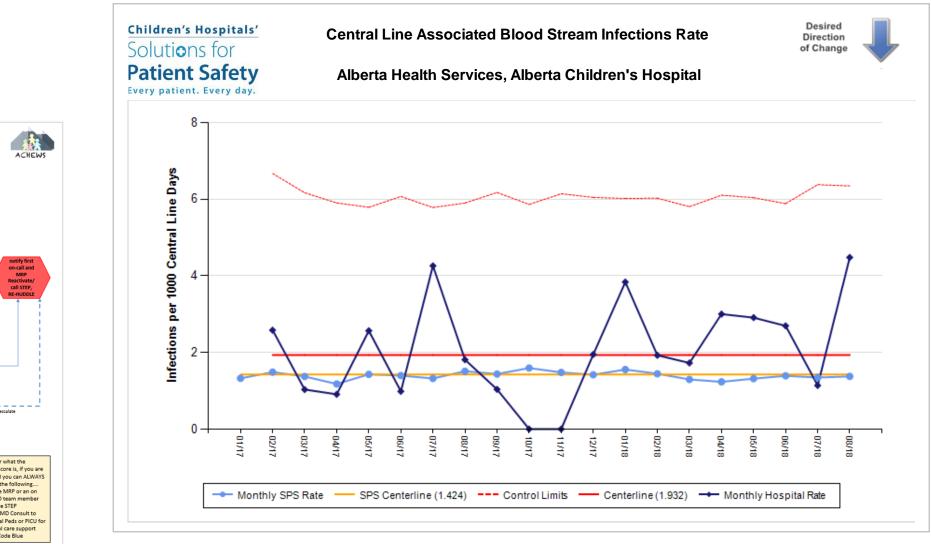
ACH EARLY WARNING SCORE

A tool, score and escalation Alberta Children's Hospit algorithm was developed and implemented, based on existing validated early warning scores, to identify and plan care for patients at risk of deterioration.

Services



In addition, rates of harm are being collected and shared with the SPS Network. Rates increase initially as we report more accurately, but are expected to decrease as we implement and monitor care bundles.



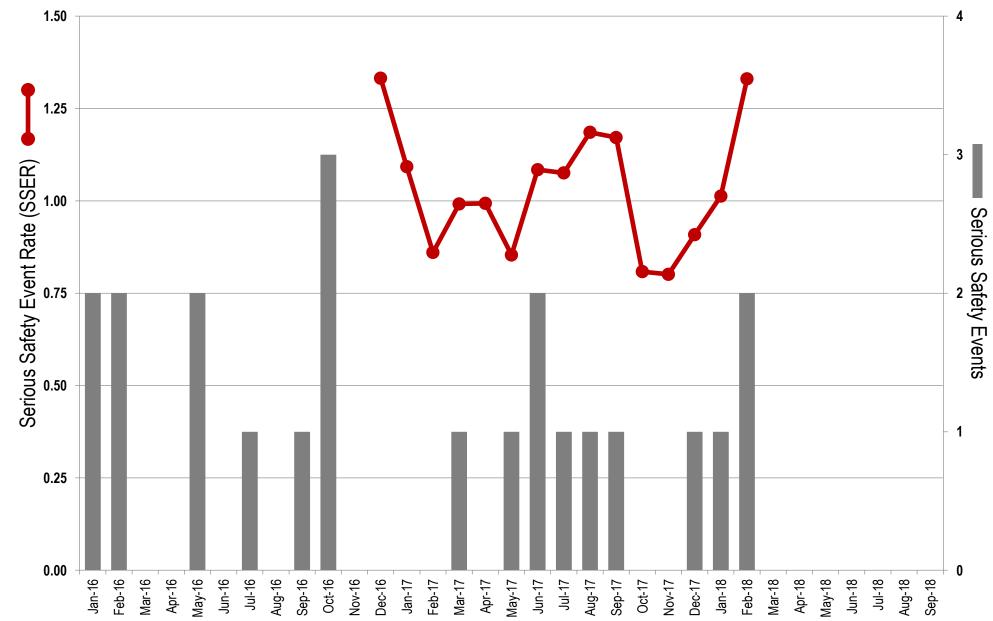
Sample report from SPS on ACH rates of CLABSI

- Adverse medication event
- Misdiagnosis
- Hospital-acquired infection
- Delay in treatment
- Wrong site surgery
- Fall with serious injury
- IV infiltration/extravasation

ACH patients experienced an SSE every **33.3** days in 2016, every **45.6** days in 2017.

Serious Safety Event Rate (SSER) Alberta Children's Hospital January 2016 to February 2018





We are striving to reach zero hospital acquired harm.

ACH Safest together core committee members:

Dr Mark Anselmo, Margaret Fullerton, Juliana Harris, Allison Hunter,

To learn more about how we're improving



ACHEWS 9 or greater

Nurse, Charge RN, first on-call MD MRP (by phone if not present), STE

ACHEWS every 1-2 hours (team to determine interval)

TEAM ESCALATION HUDDL

ACHEWS every 2-4 hours (team to determine interval)





Vanessa Nardelli, Bina Patel, Lynne Seidler, Dr Brett Simms,

J Snider, Jennifer Sullivan, Elise Teteris, Dr Jennifer Thull-Freedman.







