

Safest Together



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)**

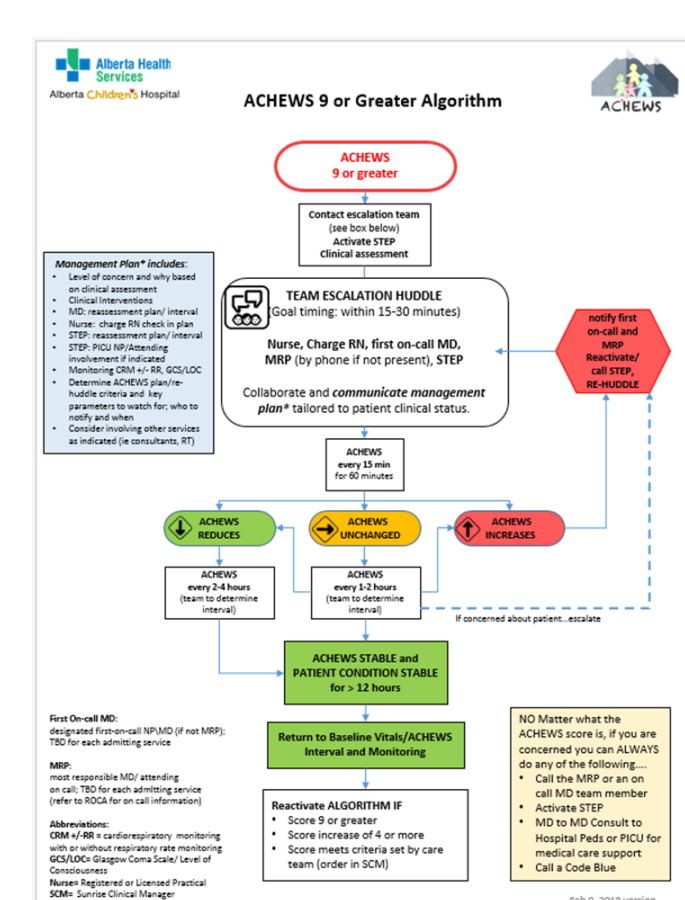
 **Surgical site infections (SSI)**

FUTURE HAC TARGETS INCLUDE:

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

ACH EARLY WARNING SCORE

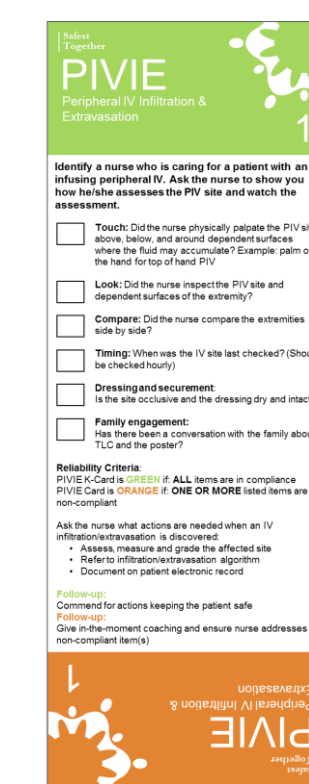
A tool, score and escalation algorithm was developed and implemented, based on existing validated early warning scores, to identify and plan care for patients at risk of deterioration.



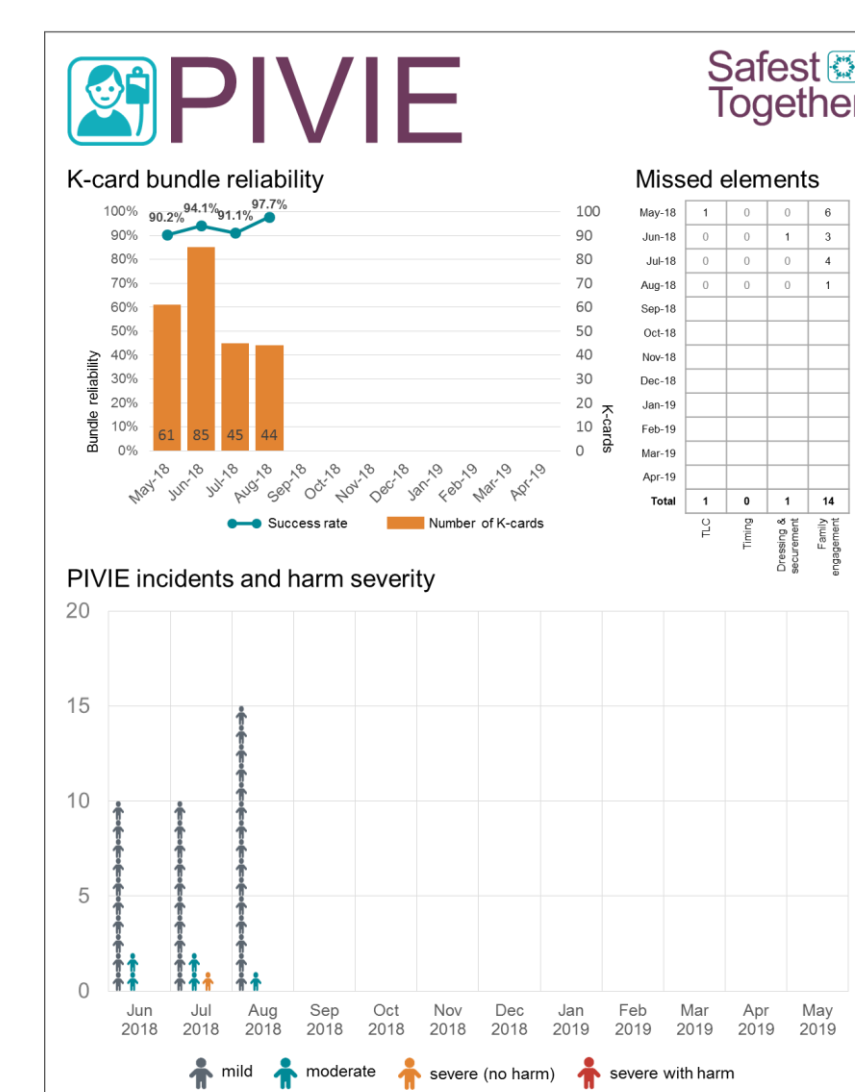
ACHEWS escalation algorithm

KAMISHIBAI CARDS (K-cards)

Care bundle implementation is tracked using the K-card method. Peer-to-peer audits are conducted to ensure all elements of the bundle are reliably being performed.



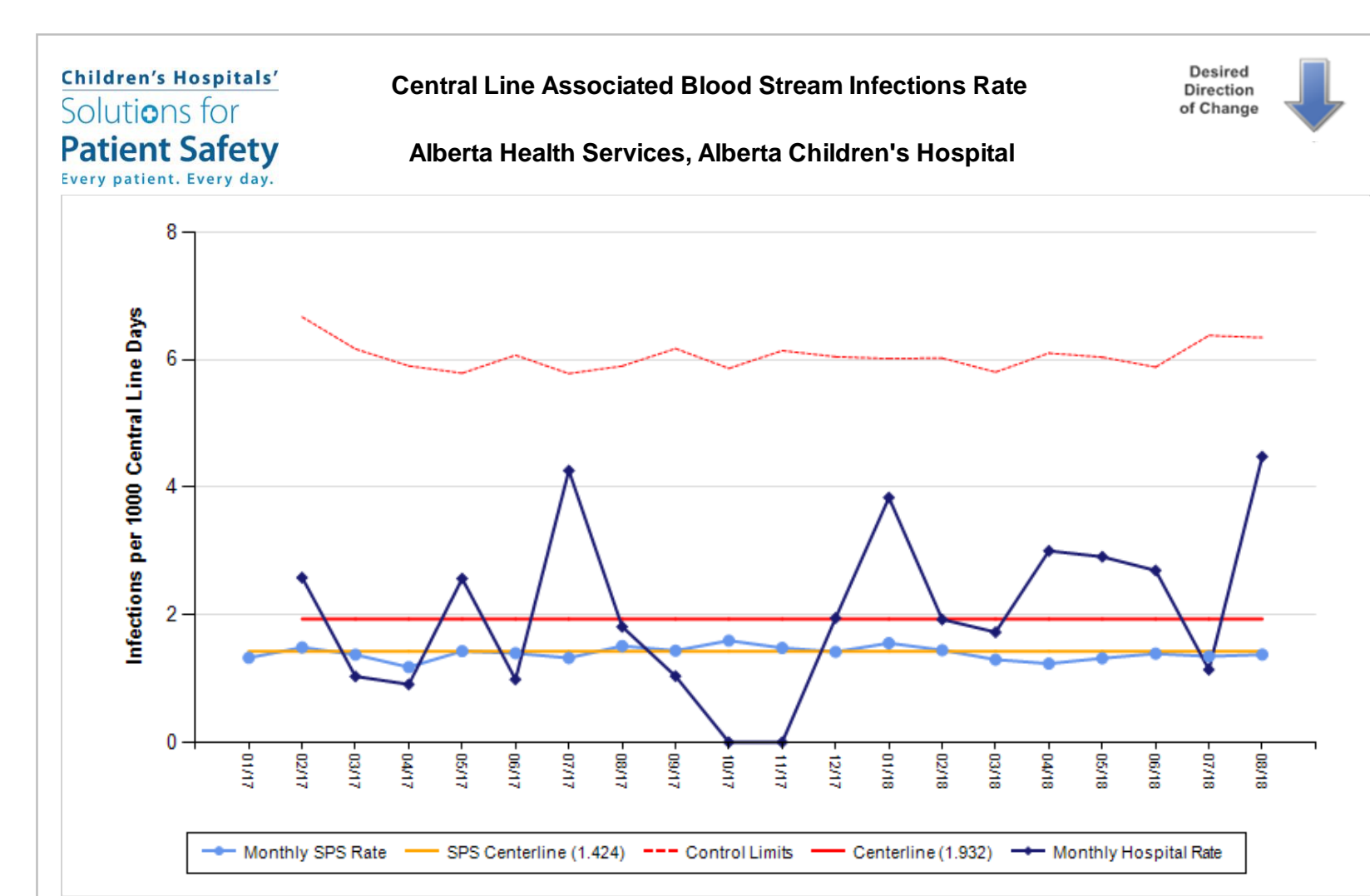
PIVIE K-card



Quality board report for PIVIE

Results of our progress towards zero harm are visibly posted throughout the hospital on quality boards.

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

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



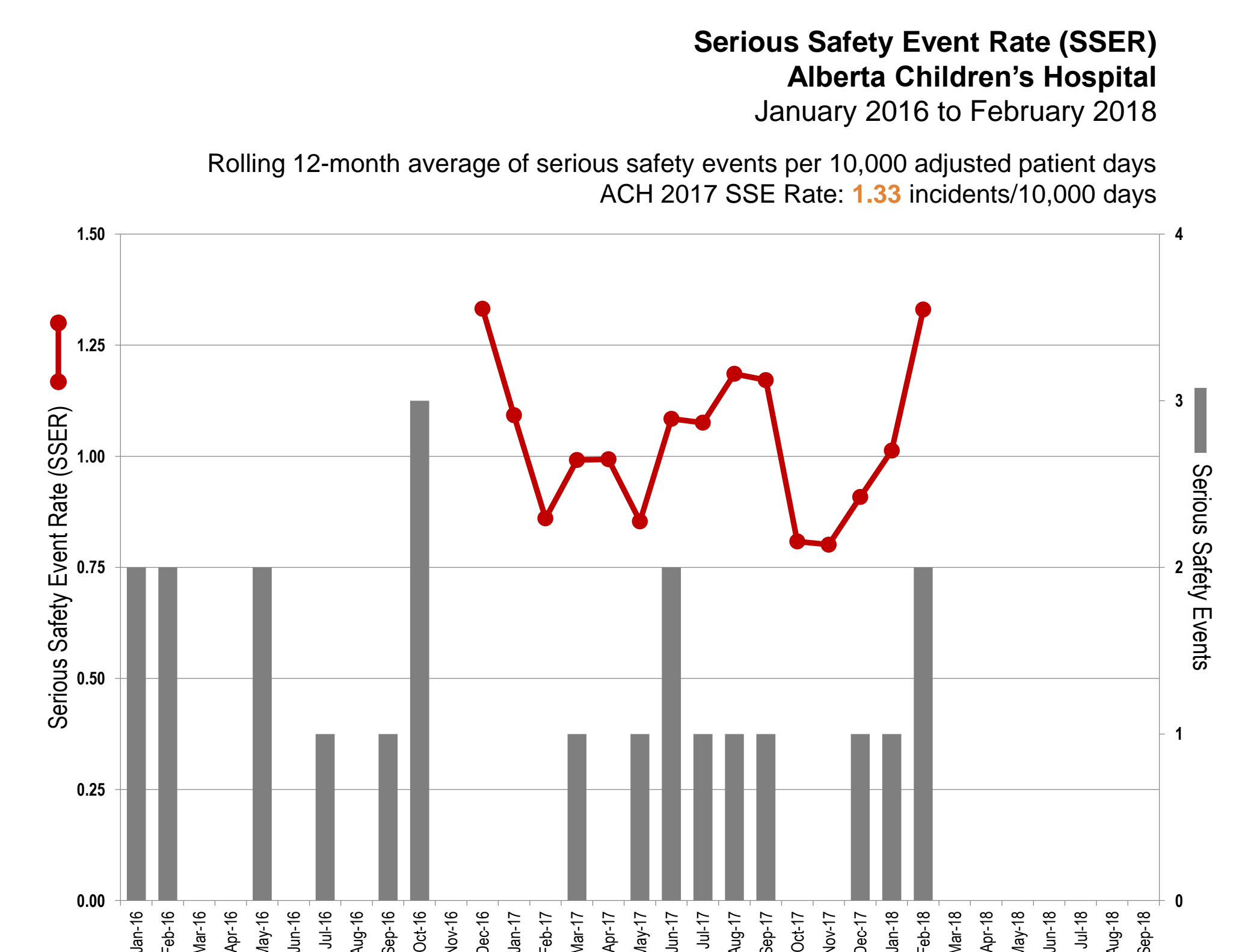
Lanyard card – error prevention tools

The bottom line

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

-  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.



We are striving to reach zero hospital acquired harm.

ACH Safest together core committee members:
 Dr Mark Anselmo, Margaret Fullerton, Juliana Harris, Allison Hunter,
 Dr Shelina Jamal, Shauna Langenberger, Suzanne Libbey,
 Vanessa Nardelli, Bina Patel, Lynne Seidler, Dr Brett Simms,
 J Snider, Jennifer Sullivan, Elise Teteris, Dr Jennifer Thull-Freedman,
 Kelly Tifford, Jill Woodward, Dr Joseph Vayalunkal

To learn more about how we're improving safety at Alberta's pediatric hospitals, contact Safest.Together@ahs.ca or visit www.ahs.ca/SafestTogether