SUMMARY:
As a result of the MGHfC Safety Reporting Review Process, we have seen (1) a decrease in post-events where a follow-up plan was created, a team was put in place, and workflow interventions completed and tracked. We have also seen (2) an increase in the filing of “near misses” and “opportunities for systems improvements” that we attribute to staff experiencing first-hand the results of these processes.

While the current regulatory climate requires all institutions to file safety events and track progress towards resolution, requirements for trending reports and making safety report information a critical component in the day to day functions of a quality and safety program are less stringent. Tracking and following up on safety events can be onerous and time consuming without a dedicated team and a clear process in place to make this information actionable.

BACKGROUND
Safety reporting is one of many vehicles to inform our work to achieve a safer environment in the hospital. Prioritization of initiatives based on safety reporting remains a challenge, as there are many sources of input without a clear methodology to attribute overall risk to an individual report. An added challenge for a children’s hospital within a hospital is to make its sometimes unique needs actionable.

Our pediatric Quality and Safety (Q&S) team has used safety reports to identify urgent needs and to identify opportunities for collaboration with other areas within the hospital. Reports undergo a confidential, peer review by the hospital’s Q&S triage team. Any report related to a pediatric patient, even if it occurred in another area of the hospital, is sent to the pediatric Q&S team. Our team meets weekly in a “safety report huddle” during which all events are reviewed and either “closed,” sent for follow-up or categorized for trending.

WHO WE ARE
MassGeneral Hospital for Children (MGHfC) is a “children’s hospital” within Massachusetts General Hospital, with more than 300 physicians, 50 medical specialties, 15 surgical services, and preventive and primary care.

MGHfC treats more than 170,000 infants, children and adolescents patients annually, including both primary care visits and specialty care visits.

Annually, more than 12,000 pediatric emergency visits, 3,000 admissions and 3,500 births take place at MGHfC.

The MGHfC Q&S Leadership Team
Executive Leaders
Vice Chair; Medical Director, MGHfC
Associate Chief Nurse Women and Children
Executive Director, MGHfC

Quality Physician Directors
Department Quality and Safety Chair* Director, Inpatient Quality and Safety Director, Outpatient Quality and Safety Director; Pediatric Surgery Quality and Safety

Quality and Safety Staff
Quality and Safety Manager* Quality Nurse Coordinator* Quality and Safety Program Coordinator

* SR Huddle Team

TABLE 1
FY11 MGHfC Safety Reports by Category (Total and Top 7)

<table>
<thead>
<tr>
<th>Category</th>
<th>Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>603</td>
</tr>
<tr>
<td>Medication/IV safety</td>
<td>144</td>
</tr>
<tr>
<td>Care/service coordination</td>
<td>103</td>
</tr>
<tr>
<td>Lab specimen/test</td>
<td>59</td>
</tr>
<tr>
<td>Diagnostic test</td>
<td>56</td>
</tr>
<tr>
<td>Safety/security/conduct</td>
<td>32</td>
</tr>
<tr>
<td>Echo/ultrasound</td>
<td>29</td>
</tr>
<tr>
<td>ID/documentation/consent</td>
<td>28</td>
</tr>
</tbody>
</table>

FIGURE 1
Safety Reporting Process at MGH and MGHfC

- Safety Report filed via desktop system
- Safety Report Documented and triaged to appropriate MGHfC Q&S team
- Safety Reporting Process at MGH and MGHfC
- Interdepartmental: Collaborative Practice
- Internal: Pediatric Process Improvement Team
- Weekly: Q&S Staff HAL-ED: Assessed a team lead, reviewed, action steps documented
- Mondays and Thursdays: all reports are received via Excel file
- Reports are categorized
- Urgent reports acted upon immediately
- Pediatric Q&S Team reviews reports in real time
- Internal: Pediatric Process Improvement Team
- Interdepartmental: Collaborative Practice

PICTURE 1
Urgent Safety Reporting Tracking Sheet

- Preliminary discussions (de-identified, general)
- Preliminary discussions (team assembled and first meeting within 48 hours)
- Rapid PDSA cycles
- Team assembled and first meeting within 48 hours
- Preliminary discussions (de-identified, general) can be conducted over email/phone
- Preliminary discussions (de-identified, general) can be conducted over email/phone
- Team assembly takes time; usually results in quarterly meetings ongoing
- Review all related cases as well as trends
- Identify next steps

FIGURE 2: MGHfC Safety Report Categorization and Next Steps

- Results in patient harm
- Uncovers urgent system risk
- Is externally reportable

Two MGHfC Quality and Executive Team Leads will be identified, available by phone and ensuring:
- Safety risk is addressed
- All coordination/tracking documentation
- All activities reviewed weekly (at minimum)
- Documentation in USR Tracking and Safety Reporting System

Internal Pediatric Improvement Team needed:
- Gain facts on case/cases
- Assemble internal team/stakeholders
- Understand current literature/best practice

Multidisciplinary/Interdepartmental improvement team needed:
- Gain facts on case/cases
- Assemble internal team/stakeholders
- Understand current literature/best practice

- Team assembled and first meeting within 48 hours
- Rapid PDSA cycles

1. Convene an appropriate group (if applicable)
2. Implement a mitigation plan for the existing safety risk
3. Identify/determine and implement a permanent solution

STUDY
DO
PLAN

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