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Children's hospitals collaborate rather than compete on patient safety

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Arkansas Children's was a founding partner in Solutions for Patient Safety, a children's hospital collaborative that shares best practices.

A safety improvement network for children's hospitals serves as an example for other emerging collaborations.

Children's hospitals in the U.S. compete fiercely with each other to attract patients from around the country and around the world. But dozens of top facilities have stopped competing in one important area—patient safety.

That's the result of nearly 140 pediatric hospitals in the U.S. and Canada joining the **Children's Hospitals Solutions for Patient Safety**, a collaboration **launched in 2012** to reduce medical errors

and adverse events.

By sharing data, adopting standardized best practices, and holding frequent learning events, Solutions for Patient Safety leaders said their members have reduced **three hospital-acquired conditions** by at least 40% from 2012 through 2018, saving 11,000 children from serious harm and producing estimated savings of $182 million.

Overall, members focus on reducing 12 hospital-acquired conditions and preventing readmissions, as well as protecting the safety of hospital staff, which Solutions for Patient Safety said is key to improving patient care. By the end of 2021, the organization's goal is to reduce the serious safety event rate at all member hospitals by 75%.

"We now realize that working alone on safety was a stupid idea," said Dr. Stephen Muething, chief quality officer at Cincinnati Children's, who helped build the national effort from a successful collaboration of eight Ohio children's hospitals. "We share everything—our monthly data, all our good stories and all our failures. Working together is the only way to pick up the pace of progress."

Reducing harm

The Children's Hospitals' Solutions for Patient Safety network advocates for best practices to prevent injuries and reduce costs. For one measure, SPS reports a decline of 1.3 infections per 1,000 catheter line days since January 2011, even while the number of participating hospitals increased.

The charts below are interactive: click or touch to see more.

Solutions for Patient Safety is an unusual example of competing healthcare organizations working together to accelerate progress in protecting patients from harm through systemic change, and it's serving as an example to other emerging collaborations. While children's hospitals traditionally have been more open than adult institutions to working together, organizers of other initiatives hope the cooperative spirit will spread.

Last month, 30 Massachusetts organizations came together to develop a statewide action plan for reducing preventable harm. The **Massachusetts Healthcare Safety and Quality Consortium**, which includes the state's largest insurer, the hospital association, the medical society and others, will set priorities for action. The effort will be led by the Betsy Lehman Center for Patient Safety, a state agency named after a Boston Globe health reporter who died from a medical error.

The consortium formed after a **Lehman Center study** found 62,000 preventable harm events resulting in $617 million in extra insurance costs in Massachusetts in 2017.

Meanwhile, the **National Steering Committee for Patient Safety**, established by the Institute for Healthcare Improvement, has corralled 27 organizations to craft a national action plan, which it

hopes to release in early 2020.

“A more coordinated approach to patient safety never really happened in the past 20 years,” said Dr. Tejal Gandhi, IHI’s chief clinical and safety officer who co-chairs the committee with Dr. Jeff Brady, the quality improvement director at the federal Agency for Healthcare Research and Quality. “The goal is to get everyone working together on core foundational areas like culture, learning systems, and patient engagement.”

Marcy Doderer, CEO of Arkansas Children’s, a founding partner in the Solutions for Patient Safety collaborative, acknowledges that creating a high-reliability organization dedicated to reducing errors and harm is all-consuming work. It requires a strongly committed CEO and board and fully engaged front-line staff, plus the participation of patients’ parents.

It’s challenging, she admits, to implement a comprehensive safety program while dealing with other pressing issues like financial health, the shift to population health management, and the workforce supply squeeze, which can distract the leadership team.

But it’s the right thing to do for patients, and is fiscally sound as well, she said. “We don’t keep a running total of cost saved for harm eliminated,” she said. “But when you deliver high-quality, safe care, it reduces staff turnover, more patients come, and the bottom line is better.”

The core work includes daily safety huddles, where executives and staff go over what happened in the last 24 hours and what’s expected in the coming 24 hours, she said. Managers pore over data on adverse events, such as unexpected intubations in the ICU, and how those problems are being solved.

Solutions for Patient Safety staff, supported by dues paid by hospital members, lead the data collection and sharing efforts, working closely with senior leaders and quality leaders at each of the hospitals.

The organization also trains CEOs and board members in establishing a culture of safety in which people aren’t penalized for making an error or flagging mistakes. That’s not easy.

“We’ve gotten to the point where people know they’re supposed to speak up when they have a concern,” said Muething, whose own hospital has made psychological safety for staff its biggest focus. “But it’s not universal yet.”

The children’s hospital collaborative helps members prevent patient harms by testing new interventions for keeping central lines clean or avoiding pressure injuries. It also allows Arkansas Children’s to compare its performance with peer hospitals. “If we’re not improving as fast as the network, that gives me pause,” Doderer said.

Unlike in the adult hospital world, the children's hospitals have developed standard measurements for patient harm events such as catheter-associated urinary tract infections, as well as standard, evidence-based care bundles for preventing those events. “You can’t do this work without agreeing on one way to measure, otherwise we’ll argue about data,” Muething said.

For example, Solutions for Patient Safety members report monthly on how reliably they are performing five standard interventions to reduce catheter-associated urinary tract infections, such as how to secure the catheter. Hospital staff members can see that doing this consistently reduces infections, helping convince them it’s effective.

All this detailed work and culture development has led to an 80% reduction in serious safety events at Arkansas Children’s over the last five years, Doderer said, though she declined to release detailed data for her hospital.

While the goal is to get to zero harm, errors still occur, she acknowledged. As recommended by the Solutions for Patient Safety network, her hospital has adopted a transparent protocol for communicating with families when something goes wrong. It immediately deploys three teams—one to talk to the family, one to conduct a rapid root-cause analysis, and a third to support the caregivers involved in the harm event.

“We make sure we have the nurse or doctor or therapist shored up, and determine whether they are ready to keep going or take time away,” she said.

Muething said the healthcare industry has not made as much progress as it should have on safety, and it needs to emulate children’s hospitals as well as other industries such as the airlines and nuclear power producers in collaborating to improve safety.

“The story in pediatrics is quite different than what’s happening in the adult world,” he said. “Trust me, it wasn’t easy. But there’s no reason why the rest of healthcare can’t do this, too.”

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