7) Enhancing Patient Safety and Quality of Care in the Pediatric Primary Care Setting

Pediatric Physicians' Organization at Children's (Boston Children's Hospital)

Elene Scheff, PT, Patient Safety Manager, Program for Patient Safety and Quality; Elene.scheff@childrens.harvard.edu

PROJECT DESCRIPTION

The hospital and associated pediatric primary care physicians organization (PO) collaborated to establish an ambulatory patient safety program in response to increasing malpractice claims and patient safety concerns in the pediatric ambulatory setting. The patient safety program uses a multi-pronged approach of education, shared learning, collaboration, and real-time support to implement sustainable change to improve the safety and quality of the care provided in pediatric primary care settings.

Education occurs through use of Learning Communities consisting of 4 in-person sessions and 3 webinars combined with monthly Safety Tips. The topics of these tips are aligned with safety event report trending and National Patient Safety Goals. The Ambulatory Risk Management Learning Community (ARM LC) is a longitudinal, interactive educational series through which the fundamentals of patient safety science are taught while promoting a culture of safe sharing. Proactive risk mitigation strategies include teaching application of adult learning principles; Clinical Microsystems tools (Plan Do Study Act cycles, process maps, fishbone diagrams, 5-Ps) to support the improvement and creation of highly-reliable processes related to closed-loop communication including, but not limited to, patient handoffs, test results and referral management, care transitions, and care across the continuum. An environment of shared learning activated a shift in the culture of patient safety. These adult learning principles were leveraged to engage diverse members of the primary care practices, both clinical and non-clinical in the patient safety work.

Proactive monthly outreach to all providers requests that they reflect on their daily work and note any vulnerability to patient safety. This program component has elicited reporting of near misses, safety events, and identified opportunities for improvement.

Real-time, continuous support from the PO patient safety program is provided by a dedicated patient safety team consisting of a Patient Safety Manager and a Quality Improvement (QI) Consultant for Patient Safety. Safety events, near misses, and requests for consultation are reported to the patient safety team by the primary care practices. The patient safety team responds in real time and utilizes patient safety principles including Root Cause Analysis (RCA) to gather details around the reported events, identify immediate needs, and provide ongoing support around implementation of action items and sustainable change necessary to prevent repeat events.

OUTCOMES ACHIEVED

- A multifaceted patient safety curriculum was successfully developed, implemented, and served as a model for future dissemination
- Practices are actively engaged around patient safety
- Practices are proactively identifying risks to patient safety and applying Clinical Microsystems tools to mitigate risk
- There has been a significant increase in safety event reports to the ambulatory patient safety team
- Over 30 quality/process improvement processes are currently in process or have been fully implemented
- Over 90% of patient safety reporting has originated from practices who have actively participated in the ambulatory risk management learning community

LESSONS LEARNED

- Patient safety integrated with quality improvement is effective for implementing a patient safety program
- An environment of shared learning and use of adult learning principles actives a shift in the culture of patient safety
- Development of proactive strategies educates and imparts change