



Children's Hospitals'
Solutions for
Patient Safety
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SPS SHINE & Transparency Report 2023

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SPS SHINE Report | 2023

Sharing Hospitals' Innovations for Network Engagement

The annual SPS Sharing Hospitals' Innovations for Network Engagement (SHINE) Report documents best practices by profiling a sample of hospitals who have demonstrated great success in a particular pediatric HAC improvement, Employee Staff Safety, culture deliverables, and/or and hospitals that have achieved a rate of statistical significance. Please email [SPS](#) with questions about this report or for additional information.

If you would like to reach out to the hospitals who are highlighted in this report, the contact information for the hospitals' project managers can be found [here](#).

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Quantitative Transparency Report*

*Organized to reflect the order of HAC's in the Network Pareto Chart.

To be included in this report, a hospital must have submitted outcomes data for at least 11 out of the 12 months and met either of the following criteria for the 12-month period of Jan. through Dec. 2022:

- They are statistically significant on the funnel plot test using 12-month rate in 2022 OR
- Their 12-month HAC rate in 2022 = zero

¹ Reflects the year 2022

² The centerline in December 2022

³ Denotes whether there was improvement from hospital's December 2021 centerline to centerline at the end of 2022; An asterisk (*) means that either: 1) the hospital's December 2021 centerline and December 2022 centerline were both zero, or 2) the hospital's December 2021 centerline was not yet established, but the December 2022 centerline was zero.

⁴ Std = Standalone; HwH/HwS = Hospital within a hospital or system

⁵ Average Patient Days per month in 2022

Note: Bed ranges were included based on self-reported or publicly available data. Hospital Type was self-reported by the hospital on the Hospital Information webform (or self-reported when they first joined SPS). NICU, PICU, CICU, and Hem-Onc are based on hospitals' responses to the Hospital Information webform (or based on unit-level monthly data submission).

Hospital	Hospital 12-Month Rate ¹	Hospital Centerline ²	Improvement ³	Hospital Type ⁴	Beds	Patient Days ⁵	NICU	PICU	CICU	Hem-Onc	Region
Unplanned Extubations (UE)-ICU											
Arnold Palmer Hospital for Children	0.222	0.145	N	HwH/HwS	150-199	2363	N	Y	Y	Y	Florida
Boston Children's Hospital	0.409	0.288	N	Std	400+	11889	Y	Y	Y	Y	New England
CHOC Children's Orange	0.238	0.057	N	Std	300-399	6328	Y	Y	Y	Y	California
Children's Health, Children's Medical Center	0.338	0.319	Y	HwH/HwS	400+	9415	Y	Y	Y	Y	Texas
Children's Healthcare of Atlanta	0.402	0.398	Y	Std	400+	16293	Y	Y	Y	Y	South
Children's Hospital Los Angeles	0.157	0.213	N	Std	300-399	9259	Y	Y	Y	Y	California
Children's Hospital of Wisconsin	0.356	0.299	N	Std	300-399	6643	Y	Y	Y	Y	Midwest
Children's Memorial Hermann Hospital	0.282	0.459	N	HwH/HwS	200-249	6328	Y	Y	Y	N	Texas
Cincinnati Children's	0.364	0.196	N	Std	400+	10923	Y	Y	Y	Y	Ohio
Cleveland Clinic Children's	0.272	0.19	N	HwH/HwS	400+	5389	Y	Y	Y	Y	Ohio
Dell Children's Medical Center of Central Texas	0.225	0.139	N	HwH/HwS	200-249	5169	Y	Y	Y	Y	Texas
Driscoll Children's Hospital	0.276	0.154	N	Std	150-199	3155	Y	Y	Y	Y	Texas
Duke Children's Hospital & Health Center	0.254	0.237	N	HwH/HwS	150-199	4785	Y	Y	Y	Y	Atlantic Coast
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota
Hassenfeld Children's Hospital at NYU Langone	0.326	0.248	N	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
Intermountain Primary Children's Hospital	0.147	0.107	N	HwH/HwS	250-299	6714	Y	Y	Y	Y	West
Joe DiMaggio Children's Hospital	0.314	0.334	N	HwH/HwS	200-249	4659	Y	Y	Y	Y	Florida
Johns Hopkins Children's Center	0.275	0.238	N	HwH/HwS	200-249	5280	Y	Y	Y	Y	Atlantic Coast
Kravis Children's Hospital at Mount Sinai	0.224	0.157	N	HwH/HwS	100-149	3822	Y	Y	Y	Y	New York
Nemours Children's Hospital, Delaware	0.266	0.266	N	HwH/HwS	250-299	4970	Y	Y	Y	Y	Atlantic Coast
New York Presbyterian Morgan Stanley Children's Hospital	0.289	0.212	N	HwH/HwS	200-249	5572	Y	Y	Y	Y	New York
Nicklaus Children's Hospital	0.183	0.115	N	Std	300-399	5810	Y	Y	Y	Y	Florida

Oklahoma Children's Hospital OU Health	0.275	0.33	N	HwH/HwS	250-299	6171	Y	Y	Y	Y	Midwest
Penn State Hershey Children's Hospital	0.244	0.281	N	HwH/HwS	100-149	3526	Y	Y	N	Y	Atlantic Coast
Phoenix Children's Hospital	0.215	0.289	N	Std	400+	8865	Y	Y	Y	Y	West
Rady Children's Hospital - San Diego	0.236	0.241	N	Std	300-399	8212	Y	Y	Y	Y	California
Randall Children's Hospital at Legacy Health	0.229	0.123	Y	HwH/HwS	150-199	3140	Y	Y	N	Y	West
St. Joseph's Children's Hospital of Tampa	0.304	0.217	Y	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
Stanford Medicine Children's Health	0.309	0.317	N	Std	300-399	9141	Y	Y	Y	Y	California
UCLA Mattel Children's Hospital	0.22	0.221	N	HwH/HwS	100-149	3442	Y	Y	Y	Y	California
UCSF Benioff Children's Hospital San Francisco	0.347	0.226	N	HwH/HwS	200-249	4849	Y	Y	Y	Y	California
University of Virginia Children's Hospital	0.277	0.291	N	HwH/HwS	100-149	3054	Y	Y	N	N	Atlantic Coast
Valley Children's Hospital	0.152	0.2	N	Std	300-399	5618	Y	Y	Y	Y	California
UE-CICU											
Arkansas Children's Hospital	0	0	*	HwH/HwS	300-399	7182	Y	Y	Y	Y	South
CHOC Children's Orange	0	0	*	Std	300-399	6328	Y	Y	Y	Y	California
Children's Hospital of Wisconsin	0.036	0	*	Std	300-399	6643	Y	Y	Y	Y	Midwest
Cook Children's Medical Center	0	0	*	HwH/HwS	400+	8903	Y	Y	Y	Y	Texas
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
Intermountain Primary Children's Hospital	0.039	0	*	HwH/HwS	250-299	6714	Y	Y	Y	Y	West
Loma Linda University Children's Hospital	0	0	*	HwH/HwS	300-399	7804	Y	Y	Y	Y	California
Nemours Children's Hospital, Florida	0	0	*	Std	100-149	2560	Y	Y	Y	Y	Florida
UE-NICU											
Advent Health for Children	0.447	0.353	N	HwH/HwS	200-249	4641	Y	Y	Y	Y	Florida
Ann & Robert H. Lurie Children's Hospital of Chicago	0.326	0.529	N	Std	300-399	8694	Y	Y	Y	Y	Midwest
CHOC Children's Orange	0.346	0.107	N	Std	300-399	6328	Y	Y	Y	Y	California
Children's Healthcare of Atlanta	0.548	0.48	Y	Std	400+	16293	Y	Y	Y	Y	South
Children's Hospital Los Angeles	0.115	0.218	N	Std	300-399	9259	Y	Y	Y	Y	California
Children's Hospital at Erlanger	0.366	0	Y	HwH/HwS	100-149	2799	Y	Y	N	Y	Tennessee CHAT
Children's Memorial Hermann Hospital	0.244	0.211	N	HwH/HwS	200-249	6328	Y	Y	Y	N	Texas
Children's of Alabama	0.413	0.522	N	Std	300-399	8498	Y	Y	Y	Y	South

Cincinnati Children's	0.33	0.276	N	Std	400+	10923	Y	Y	Y	Y	Ohio
Cleveland Clinic Children's	0.111	0	*	HwH/HwS	400+	5389	Y	Y	Y	Y	Ohio
Connecticut Children's Medical Center	0.237	0.453	N	Std	150-199	4699	Y	Y	N	Y	New England
Dell Children's Medical Center of Central Texas	0.085	0	*	HwH/HwS	200-249	5169	Y	Y	Y	Y	Texas
Driscoll Children's Hospital	0.269	0.394	N	Std	150-199	3155	Y	Y	Y	Y	Texas
Duke Children's Hospital & Health Center	0.355	0.752	N	HwH/HwS	150-199	4785	Y	Y	Y	Y	Atlantic Coast
Intermountain Primary Children's Hospital	0.153	0.121	N	HwH/HwS	250-299	6714	Y	Y	Y	Y	West
Joe DiMaggio Children's Hospital	0.222	0.351	N	HwH/HwS	200-249	4659	Y	Y	Y	Y	Florida
Johns Hopkins Children's Center	0.36	0.105	N	HwH/HwS	200-249	5280	Y	Y	Y	Y	Atlantic Coast
New York Presbyterian Morgan Stanley Children's Hospital	0.337	0.585	N	HwH/HwS	200-249	5572	Y	Y	Y	Y	New York
Nicklaus Children's Hospital	0.116	0.138	N	Std	300-399	5810	Y	Y	Y	Y	Florida
Oklahoma Children's Hospital OU Health	0.452	0.455	N	HwH/HwS	250-299	6171	Y	Y	Y	Y	Midwest
Penn State Hershey Children's Hospital	0.233	0.447	N	HwH/HwS	100-149	3526	Y	Y	N	Y	Atlantic Coast
Phoenix Children's Hospital	0.287	0.234	N	Std	400+	8865	Y	Y	Y	Y	West
Randall Children's Hospital at Legacy Health	0.232	0	Y	HwH/HwS	150-199	3140	Y	Y	N	Y	West
Riley Children's Health at Indiana University Health	0.416	0.485	N	HwH/HwS	300-399	8767	Y	Y	Y	Y	Midwest
St. Louis Children's Hospital	0.373	0.3	N	HwH/HwS	400+	9449	Y	Y	Y	Y	Midwest
UCLA Mattel Children's Hospital	0.225	0.392	N	HwH/HwS	100-149	3442	Y	Y	Y	Y	California
University of California, Davis Children's Hospital	0.145	0	*	HwH/HwS	100-149	3549	Y	Y	N	N	California
University of Virginia Children's Hospital	0.426	0.4	N	HwH/HwS	100-149	3054	Y	Y	N	N	Atlantic Coast
Valley Children's Hospital	0.229	0.236	N	Std	300-399	5618	Y	Y	Y	Y	California
UE-PICU											
Alberta Health Services, Stollery Children's Hospital	0	0	*	HwH/HwS	200-249	6223	Y	Y	Y	Y	Canada
Baystate Children's Hospital	0	0	*	HwH/HwS	100-149	1560	Y	Y	N	Y	New England
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota

K. Hovnanian Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	0-99	1606	Y	Y	N	N	Atlantic Coast
Kaiser Foundation Hospital - Santa Clara	0	0	*	HwH/HwS	0-99	907	Y	Y	N	N	California
Kravis Children's Hospital at Mount Sinai	0.048	0	*	HwH/HwS	100-149	3822	Y	Y	Y	Y	New York
Nicklaus Children's Hospital	0.133	0.045	N	Std	300-399	5810	Y	Y	Y	Y	Florida
Oklahoma Children's Hospital OU Health	0.113	0.144	N	HwH/HwS	250-299	6171	Y	Y	Y	Y	Midwest
Rady Children's Hospital - San Diego	0.07	0	*	Std	300-399	8212	Y	Y	Y	Y	California
St. Joseph's Children's Hospital of Tampa	0.095	0	Y	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
UCSF Benioff Children's Hospital Oakland	0	0	*	HwH/HwS	150-199	3505	Y	Y	N	Y	California
UH/Rainbow Babies & Children's Hospital	0	0	*	HwH/HwS	200-249	4411	Y	Y	Y	Y	Ohio
University of Virginia Children's Hospital	0.14	0.133	N	HwH/HwS	100-149	3054	Y	Y	N	N	Atlantic Coast
Valley Children's Hospital	0.082	0.274	N	Std	300-399	5618	Y	Y	Y	Y	California
Employee Serious Harm-DART											
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
El Paso Children's Hospital	0	0	Y	HwH/HwS	100-149	2286	Y	Y	N	Y	Texas
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
Ochsner Hospital for Children	0	0	*	HwH/HwS	100-149	3061	Y	Y	Y	N	South
Prisma Health Children's Hospital - Midlands	0	0	*	HwH/HwS	150-199	3766	Y	Y	N	Y	South
Employee Serious Harm-Overexertion DART											
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Johns Hopkins Children's Center	0	0	*	HwH/HwS	200-249	5280	Y	Y	Y	Y	Atlantic Coast
M Health Fairview Masonic Children's Hospital	0	0	*	HwH/HwS	200-249	3825	Y	Y	Y	Y	Minnesota
Maria Fareri Children's Hospital at WMCHHealth	0	0	*	HwH/HwS	100-149	3939	Y	Y	N	Y	New York
Our Lady of the Lake Children's Hospital	0	0	*	HwH/HwS	100-149	1897	Y	Y	N	Y	South
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
UH/Rainbow Babies & Children's Hospital	0	0	*	HwH/HwS	200-249	4411	Y	Y	Y	Y	Ohio
Employee Serious Harm-Patient Behavioral Events DART											

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Advent Health for Children	0	0	*	HwH/HwS	200-249	4641	Y	Y	Y	Y	Florida
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Helen DeVos Children's Hospital	0	0	*	HwH/HwS	250-299	5674	Y	Y	Y	Y	Midwest
K. Hovnanian Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	0-99	1606	Y	Y	N	N	Atlantic Coast
Mayo Clinic Children's Center	0	0	*	HwH/HwS	100-149	2750	Y	Y	Y	Y	Minnesota
Nationwide Children's Hospital Toledo	0	0	*	HwH/HwS	0-99	797	Y	Y	N	N	Ohio
Nemours Children's Hospital, Florida	0	0	*	Std	100-149	2560	Y	Y	Y	Y	Florida
Sutter Medical Center, Sacramento	0	0	*	HwH/HwS	100-149	2687	Y	Y	N	Y	California
University of Rochester Medical Center - Golisano Children's Hospital	0	0	*	HwH/HwS	150-199	4202	Y	Y	Y	Y	New York
Central Line Associated Blood Stream Infection (CLABSI)-Overall											
Arkansas Children's Northwest	0	0	*	HwH/HwS	0-99	578	N	N	N	N	South
Baylor Scott & White McLane Children's Medical Center	0.231	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
Loma Linda University Children's Hospital	0.567	1.044	N	HwH/HwS	300-399	7804	Y	Y	Y	Y	California
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York
Nicklaus Children's Hospital	0.471	0.554	N	Std	300-399	5810	Y	Y	Y	Y	Florida
Prisma Health Children's Hospital - Upstate	0.406	0	*	HwH/HwS	150-199	4752	Y	Y	N	Y	South
Randall Children's Hospital at Legacy Health	0.145	0.911	N	HwH/HwS	150-199	3140	Y	Y	N	Y	West
SSM Health Cardinal Glennon Children's Hospital	0.749	0.508	Y	HwH/HwS	150-199	5291	Y	Y	N	Y	Midwest
UCLA Mattel Children's Hospital	0.845	1.204	N	HwH/HwS	100-149	3442	Y	Y	Y	Y	California
UH/Rainbow Babies & Children's Hospital	0.663	0.415	N	HwH/HwS	200-249	4411	Y	Y	Y	Y	Ohio
University of Virginia Children's Hospital	0.315	0.862	N	HwH/HwS	100-149	3054	Y	Y	N	N	Atlantic Coast
Upstate Golisano Children's Hospital	0.226	0	*	HwH/HwS	0-99	1491	N	N	N	N	New York
Valley Children's Hospital	0.279	0.217	N	Std	300-399	5618	Y	Y	Y	Y	California
CLABSI-CICU											
Helen DeVos Children's Hospital	0	0	*	HwH/HwS	250-299	5674	Y	Y	Y	Y	Midwest
Johns Hopkins All Children's Hospital	0.316	1.042	N	HwH/HwS	250-299	6796	Y	Y	Y	Y	Florida

M Health Fairview Masonic Children's Hospital	0	0	*	HwH/HwS	200-249	3825	Y	Y	Y	Y	Minnesota
Nicklaus Children's Hospital	0	0	*	Std	300-399	5810	Y	Y	Y	Y	Florida
Riley Children's Health at Indiana University Health	0.528	0.855	N	HwH/HwS	300-399	8767	Y	Y	Y	Y	Midwest
St. Joseph's Children's Hospital of Tampa	0	0	*	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
UK Healthcare/Kentucky Children's Hospital	0	0	*	HwH/HwS	200-249	4102	Y	Y	Y	Y	South
UPMC Children's Hospital of Pittsburgh	0	0	Y	HwH/HwS	300-399	7996	Y	Y	Y	Y	Atlantic Coast
Wolfson Children's Hospital	0	0	*	HwH/HwS	200-249	5670	Y	Y	Y	Y	Florida
CLABSI-NICU											
Akron Children's Hospital	0	0	*	Std	400+	7991	Y	Y	N	Y	Ohio
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
Children's Hospital at Erlanger	0	0	*	HwH/HwS	100-149	2799	Y	Y	N	Y	Tennessee CHAT
Children's Hospitals and Clinics of Minnesota	0.316	0.688	N	Std	300-399	8940	Y	Y	Y	Y	Minnesota
Doernbecher Children's Hospital	0	0	*	HwH/HwS	100-149	3353	Y	Y	N	Y	West
Duke Children's Hospital & Health Center	0.154	0	*	HwH/HwS	150-199	4785	Y	Y	Y	Y	Atlantic Coast
Inova L.J. Murphy Children's Hospital	0.154	0	*	HwH/HwS	200-249	5315	Y	Y	Y	Y	Atlantic Coast
Johns Hopkins All Children's Hospital	0	0	*	HwH/HwS	250-299	6796	Y	Y	Y	Y	Florida
Joseph M Sanzari Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	100-149	2676	Y	Y	N	Y	Atlantic Coast
Kaiser Foundation Hospital - Santa Clara	0	0	*	HwH/HwS	0-99	907	Y	Y	N	N	California
Loma Linda University Children's Hospital	0.132	0	*	HwH/HwS	300-399	7804	Y	Y	Y	Y	California
Mayo Clinic Children's Center	0	0	*	HwH/HwS	100-149	2750	Y	Y	Y	Y	Minnesota
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York
Nicklaus Children's Hospital	0	0	*	Std	300-399	5810	Y	Y	Y	Y	Florida
Oklahoma Children's Hospital OU Health	0.305	0	*	HwH/HwS	250-299	6171	Y	Y	Y	Y	Midwest
Our Lady of the Lake Children's Hospital	0	0	*	HwH/HwS	100-149	1897	Y	Y	N	Y	South
Prisma Health Children's Hospital - Upstate	0.168	0	*	HwH/HwS	150-199	4752	Y	Y	N	Y	South

Randall Children's Hospital at Legacy Health	0	0	*	HwH/HwS	150-199	3140	Y	Y	N	Y	West
UCSF Benioff Children's Hospital Oakland	0	0	*	HwH/HwS	150-199	3505	Y	Y	N	Y	California
UH/Rainbow Babies & Children's Hospital	0	0	*	HwH/HwS	200-249	4411	Y	Y	Y	Y	Ohio
Valley Children's Hospital	0	0	*	Std	300-399	5618	Y	Y	Y	Y	California
CLABSI-PICU											
Arnold Palmer Hospital for Children	0	0	*	HwH/HwS	150-199	2363	N	Y	Y	Y	Florida
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
Bristol-Myers Squibb Children's Hospital	0	0	*	HwH/HwS	100-149	2417	Y	Y	N	Y	Atlantic Coast
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
Cleveland Clinic Children's	0	0	*	HwH/HwS	400+	5389	Y	Y	Y	Y	Ohio
Helen DeVos Children's Hospital	0	0	*	HwH/HwS	250-299	5674	Y	Y	Y	Y	Midwest
IWK Health Centre	0	0	*	HwH/HwS	0-99	4004	Y	Y	N	Y	Canada
Inova L.J. Murphy Children's Hospital	0	0	*	HwH/HwS	200-249	5315	Y	Y	Y	Y	Atlantic Coast
Janet Weis Children's Hospital at Geisinger Medical Center	0	0	*	HwH/HwS	0-99	2445	Y	Y	N	Y	Atlantic Coast
K. Hovnanian Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	0-99	1606	Y	Y	N	N	Atlantic Coast
Kaiser Foundation Hospital Oakland	0	0	*	HwH/HwS	0-99	1128	Y	Y	N	N	California
Kravis Children's Hospital at Mount Sinai	0	0	*	HwH/HwS	100-149	3822	Y	Y	Y	Y	New York
M Health Fairview Masonic Children's Hospital	0	0	*	HwH/HwS	200-249	3825	Y	Y	Y	Y	Minnesota
McMaster Children's Hospital Hamilton Health Sciences	0	0	*	HwH/HwS	150-199	4970	Y	Y	N	Y	Canada
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
Prisma Health Children's Hospital - Upstate	0	0	*	HwH/HwS	150-199	4752	Y	Y	N	Y	South
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
SSM Health Cardinal Glennon Children's Hospital	0	0	*	HwH/HwS	150-199	5291	Y	Y	N	Y	Midwest

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St. Joseph's Children's Hospital of Tampa	0	0	*	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
University of Vermont Children's Hospital	0	0	*	HwH/HwS	0-99	1365	Y	Y	N	N	New England
University of Virginia Children's Hospital	0.231	0	Y	HwH/HwS	100-149	3054	Y	Y	N	N	Atlantic Coast
Upstate Golisano Children's Hospital	0	0	*	HwH/HwS	0-99	1491	N	N	N	N	New York
CLABSI-Hem-Onc											
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Boston Children's Hospital	0.965	0.762	N	Std	400+	11889	Y	Y	Y	Y	New England
Children's Hospital Los Angeles	1.262	1.853	N	Std	300-399	9259	Y	Y	Y	Y	California
Children's Hospital of Philadelphia	1.342	2.159	N	Std	400+	18428	Y	Y	Y	Y	Atlantic Coast
Lehigh Valley Reilly Children's Hospital	0	0	*	HwH/HwS	0-99	2351	Y	Y	N	Y	Atlantic Coast
Levine Children's Hospital	0.697	0	*	HwH/HwS	200-249	6415	Y	Y	Y	Y	Atlantic Coast
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York
Nicklaus Children's Hospital	0.717	1.056	N	Std	300-399	5810	Y	Y	Y	Y	Florida
Our Lady of the Lake Children's Hospital	0	0	*	HwH/HwS	100-149	1897	Y	Y	N	Y	South
Phoenix Children's Hospital	1.165	2.85	N	Std	400+	8865	Y	Y	Y	Y	West
Prisma Health Children's Hospital - Upstate	0	0	*	HwH/HwS	150-199	4752	Y	Y	N	Y	South
Randall Children's Hospital at Legacy Health	0	0	*	HwH/HwS	150-199	3140	Y	Y	N	Y	West
University of Vermont Children's Hospital	0	0.986	N	HwH/HwS	0-99	1365	Y	Y	N	N	New England
Upstate Golisano Children's Hospital	0	0	*	HwH/HwS	0-99	1491	N	N	N	N	New York
Valley Children's Hospital	0.519	0	*	Std	300-399	5618	Y	Y	Y	Y	California
CLABSI-Other											
Arkansas Children's Northwest	0	0	*	HwH/HwS	0-99	578	N	N	N	N	South
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Baystate Children's Hospital	0	0	*	HwH/HwS	100-149	1560	Y	Y	N	Y	New England
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
Bristol-Myers Squibb Children's Hospital	0	0	*	HwH/HwS	100-149	2417	Y	Y	N	Y	Atlantic Coast

Children's Health, Children's Medical Center Plano	0	0	*	HwH/HwS	0-99	1842	N	Y	N	N	Texas
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
El Paso Children's Hospital	0	0	*	HwH/HwS	100-149	2286	Y	Y	N	Y	Texas
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota
Golisano Children's Hospital of SWFL	0	0	*	HwH/HwS	100-149	3157	Y	Y	N	Y	Florida
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
Helen DeVos Children's Hospital	0	0	*	HwH/HwS	250-299	5674	Y	Y	Y	Y	Midwest
Inova L.J. Murphy Children's Hospital	0	0	*	HwH/HwS	200-249	5315	Y	Y	Y	Y	Atlantic Coast
Joseph M Sanzari Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	100-149	2676	Y	Y	N	Y	Atlantic Coast
Kaiser Foundation Hospital - Santa Clara	0	0	*	HwH/HwS	0-99	907	Y	Y	N	N	California
Kaiser Permanente, Roseville	0	0	*	HwH/HwS	150-199	1971	Y	Y	N	N	California
Lehigh Valley Reilly Children's Hospital	0	0	*	HwH/HwS	0-99	2351	Y	Y	N	Y	Atlantic Coast
Mayo Clinic Children's Center	0	0	*	HwH/HwS	100-149	2750	Y	Y	Y	Y	Minnesota
Nemours Children's Hospital, Florida	0	0	*	Std	100-149	2560	Y	Y	Y	Y	Florida
NewYork-Presbyterian Komansky Children's Hospital	0	0	*	HwH/HwS	100-149	2538	Y	Y	N	N	New York
Nicklaus Children's Hospital	0	0	*	Std	300-399	5810	Y	Y	Y	Y	Florida
Prisma Health Children's Hospital - Midlands	0	0	*	HwH/HwS	150-199	3766	Y	Y	N	Y	South
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
Randall Children's Hospital at Legacy Health	0	0	*	HwH/HwS	150-199	3140	Y	Y	N	Y	West
Sutter Medical Center, Sacramento	0	0	*	HwH/HwS	100-149	2687	Y	Y	N	Y	California
UCSF Benioff Children's Hospital Oakland	0	0	*	HwH/HwS	150-199	3505	Y	Y	N	Y	California
UK Healthcare/Kentucky Children's Hospital	0	0	*	HwH/HwS	200-249	4102	Y	Y	Y	Y	South
University of Rochester Medical Center - Golisano Children's Hospital	0	0	Y	HwH/HwS	150-199	4202	Y	Y	Y	Y	New York
Valley Children's Hospital	0	0	*	Std	300-399	5618	Y	Y	Y	Y	California
Wolfson Children's Hospital	0	0	*	HwH/HwS	200-249	5670	Y	Y	Y	Y	Florida
Pressure Injury (PI)											

Advocate Children's Hospital	0.014	0	*	HwH/HwS	250-299	6550	Y	Y	Y	N	Midwest
Alberta Health Services, Alberta Children's Hospital	0	0	*	HwH/HwS	150-199	3865	Y	Y	N	Y	Canada
Arkansas Children's Hospital	0.023	0.018	N	HwH/HwS	300-399	7182	Y	Y	Y	Y	South
Arkansas Children's Northwest	0	0	*	HwH/HwS	0-99	578	N	N	N	N	South
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Beacon Children's Hospital	0	0	*	HwH/HwS	0-99	1340	Y	Y	N	Y	Midwest
Children's Health, Children's Medical Center Plano	0	0	*	HwH/HwS	0-99	1842	N	Y	N	N	Texas
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
Children's Hospital of Eastern Ontario	0	0	*	Std	150-199	3624	Y	Y	N	Y	Canada
Children's Hospital of Michigan - Detroit Medical Center	0	0	Y	HwH/HwS	200-249	6938	Y	Y	Y	Y	Midwest
Cincinnati Children's	0.031	0.025	N	Std	400+	10923	Y	Y	Y	Y	Ohio
Cohen Children's Medical Center of NY	0	0	*	HwH/HwS	200-249	4845	Y	Y	N	Y	New York
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota
Mayo Clinic Children's Center	0	0	*	HwH/HwS	100-149	2750	Y	Y	Y	Y	Minnesota
Nationwide Children's Hospital Toledo	0	0	*	HwH/HwS	0-99	797	Y	Y	N	N	Ohio
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
Texas Children's Hospital	0.055	0.019	N	Std	400+	19579	Y	Y	Y	Y	Texas
UCSF Benioff Children's Hospital San Francisco	0.017	0	*	HwH/HwS	200-249	4849	Y	Y	Y	Y	California
University of Vermont Children's Hospital	0	0	*	HwH/HwS	0-99	1365	Y	Y	N	N	New England
Yale New Haven Children's Hospital	0	0	*	HwH/HwS	200-249	4420	Y	Y	Y	Y	New England
Surgical Site Infection (SSI)											
Bristol-Myers Squibb Children's Hospital	0	0	*	HwH/HwS	100-149	2417	Y	Y	N	Y	Atlantic Coast
Covenant Children's	0	0	*	HwH/HwS	250-299	1621	Y	Y	N	N	Texas
East Tennessee Children's Hospital	0	0	*	Std	150-199	2723	Y	Y	N	N	Tennessee CHAT
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York

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IWK Health Centre	0	0	*	HwH/HwS	0-99	4004	Y	Y	N	Y	Canada
Le Bonheur Children's Hospital	0.449	1.016	N	HwH/HwS	250-299	6152	Y	Y	Y	N	Tennessee CHAT
Seattle Children's	0.791	1.197	N	Std	400+	10354	Y	Y	Y	Y	West
St. Christopher's Hospital for Children	0	0	*	HwH/HwS	100-149	2039	Y	Y	N	Y	Atlantic Coast
St. Joseph's Children's Hospital of Tampa	0	0	*	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
Valley Children's Hospital	0	0	*	Std	300-399	5618	Y	Y	Y	Y	California
Catheter Associated Urinary Tract Infection (CAUTI)											
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Bristol-Myers Squibb Children's Hospital	0	0	*	HwH/HwS	100-149	2417	Y	Y	N	Y	Atlantic Coast
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Children's Health, Children's Medical Center Plano	0	0	*	HwH/HwS	0-99	1842	N	Y	N	N	Texas
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
Children's Memorial Hermann Hospital	0	0	*	HwH/HwS	200-249	6328	Y	Y	Y	N	Texas
Comer Children's Hospital at University of Chicago Medical Center	0	0	Y	HwH/HwS	150-199	3603	Y	Y	N	Y	Midwest
Covenant Children's	0	0	*	HwH/HwS	250-299	1621	Y	Y	N	N	Texas
El Paso Children's Hospital	0	0	Y	HwH/HwS	100-149	2286	Y	Y	N	Y	Texas
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
Joe DiMaggio Children's Hospital	0	0	*	HwH/HwS	200-249	4659	Y	Y	Y	Y	Florida
Joseph M Sanzari Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	100-149	2676	Y	Y	N	Y	Atlantic Coast
K. Hovnanian Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	0-99	1606	Y	Y	N	N	Atlantic Coast
Kaiser Permanente, Roseville	0	0	*	HwH/HwS	150-199	1971	Y	Y	N	N	California
Le Bonheur Children's Hospital	0	0	*	HwH/HwS	250-299	6152	Y	Y	Y	N	Tennessee CHAT
Levine Children's Hospital	0	0	*	HwH/HwS	200-249	6415	Y	Y	Y	Y	Atlantic Coast
Loma Linda University Children's Hospital	0.268	0	Y	HwH/HwS	300-399	7804	Y	Y	Y	Y	California
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York

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Nationwide Children's Hospital Toledo	0	0	*	HwH/HwS	0-99	797	Y	Y	N	N	Ohio
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
Ochsner Hospital for Children	0	0	*	HwH/HwS	100-149	3061	Y	Y	Y	N	South
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
Randall Children's Hospital at Legacy Health	0	0	*	HwH/HwS	150-199	3140	Y	Y	N	Y	West
SSM Health Cardinal Glennon Children's Hospital	0	0	*	HwH/HwS	150-199	5291	Y	Y	N	Y	Midwest
Scottish Rite for Children	0	0	*	Std	100-149	275	N	N	N	N	Texas
Stanford Medicine Children's Health	0.572	0.546	N	Std	300-399	9141	Y	Y	Y	Y	California
The Children's Hospital of San Antonio	0	0	*	Std	250-299	3088	Y	Y	N	Y	Texas
University of Iowa Stead Family Children's Hospital	0	0	*	HwH/HwS	200-249	4248	Y	Y	Y	Y	Midwest
University of Vermont Children's Hospital	0	0	*	HwH/HwS	0-99	1365	Y	Y	N	N	New England
WVU Medicine Children's	0	0	*	HwH/HwS	100-149	2642	Y	Y	Y	Y	Atlantic Coast
Wolfson Children's Hospital	0	0	*	HwH/HwS	200-249	5670	Y	Y	Y	Y	Florida
Venous Thromboembolism Event (VTE Non-CVC)											
Advocate Children's Hospital	0	0	*	HwH/HwS	250-299	6550	Y	Y	Y	N	Midwest
Akron Children's Hospital	0	0	*	Std	400+	7991	Y	Y	N	Y	Ohio
Arkansas Children's Northwest	0	0	*	HwH/HwS	0-99	578	N	N	N	N	South
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Children's Nebraska	0	0	*	Std	200-249	3525	Y	Y	Y	Y	Midwest
Children's Hospital of Philadelphia	0.014	0	*	Std	400+	18428	Y	Y	Y	Y	Atlantic Coast
Connecticut Children's Medical Center	0	0	*	Std	150-199	4699	Y	Y	N	Y	New England
Covenant Children's	0	0	*	HwH/HwS	250-299	1621	Y	Y	N	N	Texas
Driscoll Children's Hospital	0	0	*	Std	150-199	3155	Y	Y	Y	Y	Texas
East Tennessee Children's Hospital	0	0	*	Std	150-199	2723	Y	Y	N	N	Tennessee CHAT
Golisano Children's Hospital of SWFL	0	0	*	HwH/HwS	100-149	3157	Y	Y	N	Y	Florida
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
Le Bonheur Children's Hospital	0	0	*	HwH/HwS	250-299	6152	Y	Y	Y	N	Tennessee CHAT

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Lehigh Valley Reilly Children's Hospital	0	0	*	HwH/HwS	0-99	2351	Y	Y	N	Y	Atlantic Coast
M Health Fairview Masonic Children's Hospital	0	0	*	HwH/HwS	200-249	3825	Y	Y	Y	Y	Minnesota
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York
Nemours Children's Hospital, Delaware	0	0	*	HwH/HwS	250-299	4970	Y	Y	Y	Y	Atlantic Coast
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
Scottish Rite for Children	0	0	*	Std	100-149	275	N	N	N	N	Texas
St. Joseph's Children's Hospital of Tampa	0	0	*	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
University of Rochester Medical Center - Golisano Children's Hospital	0	0	*	HwH/HwS	150-199	4202	Y	Y	Y	Y	New York
Valley Children's Hospital	0	0	*	Std	300-399	5618	Y	Y	Y	Y	California
Falls (Moderate or Greater Injury)											
Advent Health for Children	0	0	*	HwH/HwS	200-249	4641	Y	Y	Y	Y	Florida
Advocate Children's Hospital	0	0	*	HwH/HwS	250-299	6550	Y	Y	Y	N	Midwest
Akron Children's Hospital	0	0	*	Std	400+	7991	Y	Y	N	Y	Ohio
Arkansas Children's Northwest	0	0	*	HwH/HwS	0-99	578	N	N	N	N	South
Arnold Palmer Hospital for Children	0	0	*	HwH/HwS	150-199	2363	N	Y	Y	Y	Florida
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Baystate Children's Hospital	0	0	*	HwH/HwS	100-149	1560	Y	Y	N	Y	New England
Bristol-Myers Squibb Children's Hospital	0	0	*	HwH/HwS	100-149	2417	Y	Y	N	Y	Atlantic Coast
CS Mott Children's Hospital	0	0	*	HwH/HwS	200-249	6487	Y	Y	Y	Y	Midwest
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Children's Health, Children's Medical Center Plano	0	0	*	HwH/HwS	0-99	1842	N	Y	N	N	Texas
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
Children's Hospital at Erlanger	0	0	*	HwH/HwS	100-149	2799	Y	Y	N	Y	Tennessee CHAT
Children's Hospital of Eastern Ontario	0	0	*	Std	150-199	3624	Y	Y	N	Y	Canada
Children's Hospital of Illinois at OSF Healthcare	0	0	*	HwH/HwS	100-149	3147	Y	Y	N	Y	Midwest
Children's Hospital of Wisconsin - Fox Valley	0	0	*	HwH/HwS	0-99	486	Y	N	N	N	Midwest

Children's Hospitals and Clinics of Minnesota	0	0	*	Std	300-399	8940	Y	Y	Y	Y	Minnesota
Children's National Medical Center	0	0	*	Std	300-399	8922	Y	Y	Y	Y	Atlantic Coast
Children's of Mississippi	0	0	*	HwH/HwS	250-299	5221	Y	Y	Y	Y	South
Cohen Children's Medical Center of NY	0	0	*	HwH/HwS	200-249	4845	Y	Y	N	Y	New York
Dell Children's Medical Center of Central Texas	0	0	*	HwH/HwS	200-249	5169	Y	Y	Y	Y	Texas
El Paso Children's Hospital	0	0	*	HwH/HwS	100-149	2286	Y	Y	N	Y	Texas
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota
Golisano Children's Hospital of SWFL	0	0	*	HwH/HwS	100-149	3157	Y	Y	N	Y	Florida
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
Holland Bloorview Kids Rehabilitation Hospital	0	0	Y	Std	0-99	1502	N	N	N	N	Canada
Janet Weis Children's Hospital at Geisinger Medical Center	0	0	*	HwH/HwS	0-99	2445	Y	Y	N	Y	Atlantic Coast
Le Bonheur Children's Hospital	0	0	*	HwH/HwS	250-299	6152	Y	Y	Y	N	Tennessee CHAT
Lehigh Valley Reilly Children's Hospital	0	0	*	HwH/HwS	0-99	2351	Y	Y	N	Y	Atlantic Coast
Levine Children's Hospital	0	0	*	HwH/HwS	200-249	6415	Y	Y	Y	Y	Atlantic Coast
M Health Fairview Masonic Children's Hospital	0	0	*	HwH/HwS	200-249	3825	Y	Y	Y	Y	Minnesota
MUSC Shawn Jenkins Children's Hospital	0	0	*	HwH/HwS	150-199	5146	Y	Y	Y	Y	South
Maria Fareri Children's Hospital at WMCHHealth	0	0	*	HwH/HwS	100-149	3939	Y	Y	N	Y	New York
Mary Bridge Children's Hospital & Health Network	0	0	*	HwH/HwS	0-99	1417	N	Y	N	Y	West
Mayo Clinic Children's Center	0	0	*	HwH/HwS	100-149	2750	Y	Y	Y	Y	Minnesota
McMaster Children's Hospital Hamilton Health Sciences	0	0	*	HwH/HwS	150-199	4970	Y	Y	N	Y	Canada
Monroe Carell Jr. Children's Hospital at Vanderbilt	0	0	*	HwH/HwS	250-299	9840	Y	Y	Y	Y	Tennessee CHAT
Nationwide Children's Hospital Toledo	0	0	*	HwH/HwS	0-99	797	Y	Y	N	N	Ohio
Nemours Children's Hospital, Delaware	0	0	*	HwH/HwS	250-299	4970	Y	Y	Y	Y	Atlantic Coast
Nemours Children's Hospital, Florida	0	0	*	Std	100-149	2560	Y	Y	Y	Y	Florida

NewYork-Presbyterian Komansky Children's Hospital	0	0	*	HwH/HwS	100-149	2538	Y	Y	N	N	New York
Nicklaus Children's Hospital	0	0	*	Std	300-399	5810	Y	Y	Y	Y	Florida
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
North Carolina Children's Hospital	0	0	*	HwH/HwS	150-199	4039	Y	Y	Y	Y	Atlantic Coast
Norton Children's Hospital	0	0	*	HwH/HwS	250-299	6487	Y	Y	Y	Y	South
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
Randall Children's Hospital at Legacy Health	0	0	*	HwH/HwS	150-199	3140	Y	Y	N	Y	West
Scottish Rite for Children	0	0	*	Std	100-149	275	N	N	N	N	Texas
Stanford Medicine Children's Health	0	0	*	Std	300-399	9141	Y	Y	Y	Y	California
Sutter Medical Center, Sacramento	0	0	*	HwH/HwS	100-149	2687	Y	Y	N	Y	California
The Children's Hospital of San Antonio	0	0	*	Std	250-299	3088	Y	Y	N	Y	Texas
The Hospital for Sick Children	0	0	*	Std	300-399	8751	Y	Y	Y	Y	Canada
UCSF Benioff Children's Hospital San Francisco	0	0	*	HwH/HwS	200-249	4849	Y	Y	Y	Y	California
UH/Rainbow Babies & Children's Hospital	0	0	*	HwH/HwS	200-249	4411	Y	Y	Y	Y	Ohio
University of California, Davis Children's Hospital	0	0	*	HwH/HwS	100-149	3549	Y	Y	N	N	California
University of Rochester Medical Center - Golisano Children's Hospital	0	0	*	HwH/HwS	150-199	4202	Y	Y	Y	Y	New York
University of Vermont Children's Hospital	0	0	*	HwH/HwS	0-99	1365	Y	Y	N	N	New England
University of Virginia Children's Hospital	0	0	*	HwH/HwS	100-149	3054	Y	Y	N	N	Atlantic Coast
Valley Children's Hospital	0	0	*	Std	300-399	5618	Y	Y	Y	Y	California
WVU Medicine Children's	0	0	*	HwH/HwS	100-149	2642	Y	Y	Y	Y	Atlantic Coast
Adverse Drug Event (ADE Levels F-I)											
Akron Children's Hospital	0	0	*	Std	400+	7991	Y	Y	N	Y	Ohio
Ann & Robert H. Lurie Children's Hospital of Chicago	0	0	*	Std	300-399	8694	Y	Y	Y	Y	Midwest
Arkansas Children's Hospital	0	0	*	HwH/HwS	300-399	7182	Y	Y	Y	Y	South
Arkansas Children's Northwest	0	0	*	HwH/HwS	0-99	578	N	N	N	N	South
Baylor Scott & White McLane Children's Medical Center	0	0	*	HwH/HwS	100-149	2825	Y	Y	N	Y	Texas
Boston Children's Hospital	0	0	*	Std	400+	11889	Y	Y	Y	Y	New England

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CHOC Children's Orange	0	0	*	Std	300-399	6328	Y	Y	Y	Y	California
Carilion Medical Center, Carilion Children's	0	0	*	HwH/HwS	0-99	1746	Y	Y	N	Y	Atlantic Coast
Children's Health, Children's Medical Center Plano	0	0	*	HwH/HwS	0-99	1842	N	Y	N	N	Texas
Children's Healthcare of Atlanta	0	0	*	Std	400+	16293	Y	Y	Y	Y	South
Children's Nebraska	0	0	*	Std	200-249	3525	Y	Y	Y	Y	Midwest
Children's Hospital New Orleans	0	0	*	HwH/HwS	200-249	5080	Y	Y	Y	Y	South
Children's Hospital at Dartmouth-Hitchcock	0	0	*	HwH/HwS	0-99	1245	Y	Y	N	N	New England
Children's Hospital of Eastern Ontario	0	0	Y	Std	150-199	3624	Y	Y	N	Y	Canada
Children's Hospital of Illinois at OSF Healthcare	0	0	*	HwH/HwS	100-149	3147	Y	Y	N	Y	Midwest
Children's Hospital of Philadelphia	0	0	*	Std	400+	18428	Y	Y	Y	Y	Atlantic Coast
Children's Hospital of Wisconsin	0	0	*	Std	300-399	6643	Y	Y	Y	Y	Midwest
Children's Mercy Kansas City	0	0	*	HwH/HwS	300-399	8600	Y	Y	Y	Y	Midwest
Children's National Medical Center	0	0	*	Std	300-399	8922	Y	Y	Y	Y	Atlantic Coast
Children's of Alabama	0	0	*	Std	300-399	8498	Y	Y	Y	Y	South
Connecticut Children's Medical Center	0	0	*	Std	150-199	4699	Y	Y	N	Y	New England
Dayton Children's Hospital	0	0	*	Std	150-199	3781	Y	Y	N	Y	Ohio
Dell Children's Medical Center of Central Texas	0	0	*	HwH/HwS	200-249	5169	Y	Y	Y	Y	Texas
Driscoll Children's Hospital	0	0	*	Std	150-199	3155	Y	Y	Y	Y	Texas
East Tennessee Children's Hospital	0	0	*	Std	150-199	2723	Y	Y	N	N	Tennessee CHAT
Gillette Children's Specialty Healthcare	0	0	*	Std	0-99	768	N	Y	N	N	Minnesota
Golisano Children's Hospital of SWFL	0	0	*	HwH/HwS	100-149	3157	Y	Y	N	Y	Florida
Hasbro Children's Hospital	0	0	*	HwH/HwS	0-99	2068	N	Y	N	Y	New England
Hassenfeld Children's Hospital at NYU Langone	0	0	*	HwH/HwS	100-149	2837	Y	Y	Y	N	New York
IWK Health Centre	0	0	*	HwH/HwS	0-99	4004	Y	Y	N	Y	Canada
Joe DiMaggio Children's Hospital	0	0	*	HwH/HwS	200-249	4659	Y	Y	Y	Y	Florida
Johns Hopkins All Children's Hospital	0	0	*	HwH/HwS	250-299	6796	Y	Y	Y	Y	Florida
Johns Hopkins Children's Center	0	0	*	HwH/HwS	200-249	5280	Y	Y	Y	Y	Atlantic Coast

K. Hovnanian Children's Hospital at Hackensack Meridian Health	0	0	*	HwH/HwS	0-99	1606	Y	Y	N	N	Atlantic Coast
Kaiser Permanente, Roseville	0	0	*	HwH/HwS	150-199	1971	Y	Y	N	N	California
Le Bonheur Children's Hospital	0	0	*	HwH/HwS	250-299	6152	Y	Y	Y	N	Tennessee CHAT
Loma Linda University Children's Hospital	0	0	*	HwH/HwS	300-399	7804	Y	Y	Y	Y	California
Maria Fareri Children's Hospital at WMCHealth	0	0	*	HwH/HwS	100-149	3939	Y	Y	N	Y	New York
NYU Langone Hospital - Long Island Children's Medical Center	0	0	*	HwH/HwS	0-99	2166	Y	Y	N	Y	New York
Nationwide Children's Hospital Toledo	0	0	*	HwH/HwS	0-99	797	Y	Y	N	N	Ohio
Nemours Children's Hospital, Delaware	0	0	*	HwH/HwS	250-299	4970	Y	Y	Y	Y	Atlantic Coast
New York Presbyterian Morgan Stanley Children's Hospital	0	0	*	HwH/HwS	200-249	5572	Y	Y	Y	Y	New York
NewYork-Presbyterian Komansky Children's Hospital	0	0	*	HwH/HwS	100-149	2538	Y	Y	N	N	New York
Niswonger Children's Hospital	0	0	*	HwH/HwS	0-99	1811	Y	Y	N	Y	Tennessee CHAT
Ochsner Hospital for Children	0	0	*	HwH/HwS	100-149	3061	Y	Y	Y	N	South
Penn State Hershey Children's Hospital	0	0	*	HwH/HwS	100-149	3526	Y	Y	N	Y	Atlantic Coast
Prisma Health Children's Hospital - Midlands	0	0	*	HwH/HwS	150-199	3766	Y	Y	N	Y	South
ProMedica Russell J. Ebeid Children's Hospital	0	0	*	HwH/HwS	150-199	2755	Y	Y	N	Y	Ohio
Scottish Rite for Children	0	0	*	Std	100-149	275	N	N	N	N	Texas
St. Joseph's Children's Hospital of Tampa	0	0	*	HwH/HwS	200-249	3669	Y	Y	Y	Y	Florida
The Children's Hospital of San Antonio	0	0	*	Std	250-299	3088	Y	Y	N	Y	Texas
UCSF Benioff Children's Hospital Oakland	0	0	*	HwH/HwS	150-199	3505	Y	Y	N	Y	California
UPMC Children's Hospital of Pittsburgh	0	0	*	HwH/HwS	300-399	7996	Y	Y	Y	Y	Atlantic Coast
University of Rochester Medical Center - Golisano Children's Hospital	0	0	*	HwH/HwS	150-199	4202	Y	Y	Y	Y	New York
University of Vermont Children's Hospital	0	0	*	HwH/HwS	0-99	1365	Y	Y	N	N	New England
Yale New Haven Children's Hospital	0	0	*	HwH/HwS	200-249	4420	Y	Y	Y	Y	New England

Hospital Highlights

In this section of the report, we are highlighting a sample of hospitals who have demonstrated great success in a pediatric Hospital Acquired Condition (HAC) improvement, Employee Staff Safety, culture deliverable, or network priority. Contact information for these hospitals is included in order to facilitate hospital-to-hospital “All Teach, All Learn.” The hospitals within this report are eager to share their learnings and welcome you to reach out to them.

The hospitals in this report were selected based on the data submitted in 2022 and subsequent achievements in the HAC or culture domain. All data/information (i.e., Top Interventions, Sustainment Strategy, Actively Testing, etc.) was provided by the hospitals. Please note that SPS does not endorse any specific brands or products mentioned by the hospitals.

Adverse Drug Events (ADE) – Levels F-I

Hospital & Contact Info	Best Practices & Highlights
<p>Children’s Hospital of Eastern Ontario</p> <p>Jill Sullivan, JSullivan@cheo.on.ca</p> <p>Dave Creery, dcreery@cheo.on.ca</p> <p>Nisha Varughese, nvarughese@cheo.on.ca</p> <p>Martha Pinheiro-Maltez, mpinheiro@cheo.on.ca</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Epic Computerized Provider Order Entry (CPOE) and order sets drive evidence-based therapy and appropriate dosing for pediatric patients • Barcode medication administration compliance auditing • Medication reconciliation for all admitted patients <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Pharmacy and Therapeutics Committee - medication safety review <ul style="list-style-type: none"> ○ Reviewing metrics ○ Identifying risks and mitigation strategies • Adverse drug reactions reporting within Epic • Healthcare Information and Management Systems Society (HIMSS): <ul style="list-style-type: none"> ○ Barcode medication administration compliance readiness ○ Dashboard created within Epic to monitor compliance <ul style="list-style-type: none"> ▪ CPOE compliance rate ▪ Patient scanning ▪ Medications ▪ Other (blood products, feeding products, expressed breast milk, blood specimen, etc.) ○ User interaction checking (checking for alert fatigue, duplicate alerts) ○ Best practice advisory and alignment of alerts with best practice ○ Embedding clinical reference materials into Epic <p>Actively Testing: Children’s Hospital of Eastern Ontario (CHEO) is not actively testing.</p> <p>Additional Information: For outcomes detection, CHEO uses their safety reporting system and work group who meets monthly to review and classify all medication-related events. The hospital reports that they recognize this approach relies on staff entering medication-related events and therefore there may be an unknown quantity that is not reported. However, they state they do have a strong culture of reporting serious ADE and are 80% confident that their detection methods capture ADEs hospital-wide. Subsequently, 100% of the medication-related events reported are being reviewed and classified using NCC-MERP (National Coordinating Council for Medication Error Reporting and Prevention).</p>

	<p>CHEO uses a pharmacy intervention database to minimize ordering errors and is conducting a smart pump analysis to mitigate identified gaps from the smart pump data to minimize administration errors.</p> <p>EMR: Epic</p>
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Catheter-Associated Urinary Tract Infections (CAUTI)

The following hospitals report that they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Loma Linda University Children's Hospital</p> <p>Kelly Flood, KFlood@llu.edu</p> <p>Beth Rankin, ERankin@llu.edu</p> <p>Ashley Anderson, ANAnderson@llu.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Daily evaluation of reason for continuing catheter use • Expectation of foley catheter care at least once per shift • Expectation to keep a closed drainage system, to keep bag below level of bladder, to maintain unobstructed flow of urine, and frequent emptying of the collection bag <p>Sustainment Strategy: CAUTI improvement work at Loma Linda University Children's Hospital (LLUCH) sustained.ni</p> <p>Actively Testing: LLUCH is not actively testing.</p> <p>Additional Information: For outcomes detection, LLUCH uses VigiLanz as a trigger tool to monitor outcomes. They have implemented all standard and recommended bundle elements house-wide. The hospital states they put an emphasis on the recommended element: daily evaluation of needs of the catheter.</p> <p>EMR: Epic</p>
<p>Oklahoma Children's Hospital OU Health</p> <p>Kristi Booker, Kristi.Booker@ouhealth.com</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Send list of all patients with foleys daily to leadership/supervisors, physicians on the units, and uppers such as the CNO, CMO, and Quality Director • Personal follow ups with unit leadership if the foley is in for greater than two days <p>Sustainment Strategy: Oklahoma Children's Hospital OU Health (Oklahoma) states they continue to keep lines of communication open and do rounds on the units to ensure they are providing appropriate care to patients.</p> <p>Actively Testing: This hospital is not actively testing.</p> <p>Additional Information: For outcomes detection, Oklahoma goes over surveillance each morning from Buggy and sees if there are any HACs that need to be followed-up with. They then will send an email to leadership and will discuss at their morning meeting. The hospital has implemented all standard and recommended bundle elements house-wide.</p>

EMR: Epic

Central Line–Associated Blood Stream Infections (CLABSI)

The following hospitals report that they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Arkansas Children’s Hospital</p> <p>Carol Oldridge, OldridgeCL@archildrens.org</p> <p>Elizabeth Marrero, MarreroEM@archildrens.org</p> <p>Ellen Mallard, MallardTE@archildrens.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • A strong, engaged, multi-disciplinary CLABSI Leadership Team that meets monthly to adapt improvement strategy and triage barriers with central line maintenance, insertion, or supplies. Multi-disciplinary CLABSI Leadership team includes roles from neonatal, pediatric, and pediatric cardiac intensive care units, process engineers, purchasing, vascular access, infection prevention, and a senior vice president. • Quality/CLABSI reduction nurse roles were established on units to triage barriers found in observations, apparent cause analysis, rounds with infection prevention, or concerns from staff, patients, and caregivers. This unit-based nursing role intervention was published in <i>Neonatal Network, 2021</i> (PubMed Link) • Infection Prevention (IP) Team member dedicated to CLABSI prevention was added and developed unit level specific A3 project summaries to communicate trends and learnings to the front-line providers • A parent representative in hospital-wide CLABSI meeting was added. The hospital recently added this role and so far, has found their input invaluable <p>Sustainment Strategy: Education, engagement, and communication through the hospital-wide CLABSI meetings where representatives from all clinical areas are involved and responsible for communicating the information to their bedside staff and clinical leadership</p> <p>Actively Testing: Arkansas Children’s Hospital (ACH) is actively testing. They continue to test new ideas and products, some due to necessity related to supply-chain issues. They are specifically testing the use of passive alcohol protective caps for use on needleless connectors on the catheter and tubing sets. This is to prevent “looping” of the line back onto the tubing or using other items (or nothing) to protect the IV tubing when a patient is disconnected for any period of time.</p> <p>Additional Information: For outcomes detection, the infection prevention team performs surveillance using the Epic Buggy dashboard. They have several reports they review to identify positive cultures. They also review patient lists and round in units. Infection prevention team review each positive culture to determine if it is an infection by following the Centers for Disease Control and Prevention’s National Healthcare Safety Network criteria for CLABSIs.</p> <p>ACH has implemented all standard bundle elements house-wide. Of the recommended elements, the hospital has implemented in-depth Apparent Cause Analysis (ACA) of all identified CLABSIs with multidisciplinary involvement to identify action items with the intent to change the process if needed. This process is encouraged, and the hospital reports some areas do it well, while others have challenges. All areas are required to</p>

	<p>maintain a current A3 project summary for CLABSI and daily linen changes. Parents are also asked to launder their home linen daily, and the hospital encourages them to bring more than one item so they do not have to do laundry every day.</p> <p>EMR: Epic</p>
<p>Baylor Scott & White McLane Children's Medical Center</p> <p>Audrey Hubbard, audrey.hubbard@bswhealth.org</p> <p>DeAnna Schreier, deanna.schreier@bswhealth.org</p> <p>Kelly Horn, kelly.horn@bswhealth.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Daily treatment of Theraworx application • Accountability: Review of line with shift change and transfer, audits, holding each other accountable for discrepancies in bundle elements, use of aseptic work surface when accessing line, and event reviews • Patient Education: Oral care, Theraworx, dressing integrity/ two person dressing change process by unit champions <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • A multidisciplinary vascular access council to discuss products, bundle compliance, education, and event review learnings • Accountability of staff • Unit champions for a resource <p>Actively Testing: Baylor Scott & White McLane Children's Medical Center (McLane Children's) is actively testing and participating in the Texas Region patient hand hygiene project, which reviews patient compliance with hand hygiene and education provided prior to meals with the outcome metric of CLABSI rate in the medical surgical department.</p> <p>Additional Information: For outcomes detection, McLane Children's uses the EMR Data Mining System, Buggy.</p> <p>Of the standard bundle elements, they use daily treatment of Theraworx and not CHG. With their Theraworx trial, they had had higher compliance of use and no increase in CLABSI including MBI CLABSI's events after implementation. Of the recommended elements, the hospital conducts in-depth reviews of all identified CLABSI with multidisciplinary involvement and the intent to change the process if needed, as well as daily linen changes. These elements are implemented house-wide (PICU, NICU, Med-Surg, HemOnc).</p> <p>EMR: Epic</p>
<p>Penn State Hershey Children's Hospital</p> <p>Desiree Jacobs, djacobs1@pennstatehealth.psu.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Two of the hospital's units, Pediatric Hematology and PICU, experienced the greatest reductions: <ul style="list-style-type: none"> ○ Pediatric Hematology/Oncology <ul style="list-style-type: none"> ▪ In October 2021, Penn State Hershey Children's Hospital (Penn State Hershey) joined the SPS Hem/Onc Pioneer Cohort and focused on utilizing a dedicated space for aseptic access of central lines. Utilizing this space helped ensure they kept supplies clean when accessing a central line

	<p>attending the house-wide HAC meeting to discuss their current CLABSI practice</p> <p>Actively Testing: The hospital is not actively testing.</p> <p>Additional Information: For outcomes detection, Penn State Hershey’s Infection Prevention (IP) Team uses an electronic surveillance program (TheraDoc). Culture and other laboratory test results are reviewed by the Infection Preventions Consultants. Using TheraDoc logic for identification and CDC definition for infections, IP determines if criteria are met for a HAI. All HAIs are entered into the NHSN. In addition to the electronic surveillance, they also receive a daily positive blood culture report from the lab.</p> <p>The hospital has implemented all standard and recommended bundle elements house-wide, including daily linen changes.</p> <p>EMR: Cerner</p>
<p>University of Virginia Children's Hospital</p> <p>Shantal Savage, SVS7C@uvahealth.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Multidisciplinary approach to CLABSI – family-centered, interdisciplinary rounds with daily line review and discussion • Patient Safety Risk Rounds that integrate huddles, visual management tool, and standard work to assure each patient’s unique CLABSI-related risks are mitigated each shift • Strong physician and leadership engagement to keep CLABSI a priority, such as line challenge rounds <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Refreshing audit practice • Enhanced shared learning across units/clinics <p>Actively Testing: University of Virginia Children's Hospital (UVA Children’s Hospital) is actively testing developing a HAC Team for the Children’s Hospital to share learnings across inpatient units and outpatient clinics, and to systematically review their practice.</p> <p>Additional Information: For outcomes detection, UVA Children’s Hospital notifies their Infection Control & Prevention (IP&C) Team when cultures are sent to the lab. They monitor results and automatically notify the unit and leaders when a culture turns positive. Both IP&C and Clinic Teams investigate the case to determine whether the infection is a CLABSI.</p> <p>All standard elements are implemented house-wide, except a daily CHG bath as some providers opt out for their patients. Of the recommended elements, the hospital does in-depth review of all identified CLABSIs house-wide.</p> <p>EMR: Epic</p>
<p>Upstate Golisano Children’s Hospital</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Removing line when no longer clinically indicated

<p>Michelle Jeski, jeskim@upstate.edu</p>	<ul style="list-style-type: none"> • Chlorhexidine gluconate (CHG) documentation on Medication Administration Record (MAR) • Smart phrase for daily discussion of need and considerations to decrease access <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • K-card documentation in the Emergency Medical Records • Quality rounds when indicated • Multidisciplinary huddles when CLABSI occurs to review care and identify opportunities for improvement <p>Actively Testing: Upstate Golisano Children’s Hospital (Upstate Golisano) is not actively testing.</p> <p>Additional Information: For outcomes detection, Upstate Golisano has Infection Control conduct active surveillance and reviews positive blood cultures to determine if the patient meets CLABSI criteria.</p> <p>Upstate Golisano has implemented all standard bundle elements throughout all units of the Children’s Hospital. Of the recommended elements, the hospital does daily linen changes and an in-depth review of all identified CLABSIs with multidisciplinary involvement and the intent to change the process if needed.</p> <p>EMR: Epic</p>
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Central Line–Associated Blood Stream Infections Hematology-Oncology (CLABSI Hem-Onc)*

*CLABSIs described in this section reference CLABSIs in the inpatient Hematology-Oncology population
The following hospitals report that they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Bristol-Myers Squibb Children’s Hospital</p> <p>Pamela Stone, pamela.stone2@rwjbh.org</p> <p>Becky Ramos, Rebecca.ramos@rwjbh.org</p> <p>Sue Fastenau, set4@cinj.rutgers.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Bristol-Myers Squibb Children’s Hospital (BMSCH) has tested and spread a “Bathing, Brushing, Ambulation, Mouth” (BBAM) procedure for Hem-Onc patients, including bathing or showering daily with CHG, brushing teeth twice a day, patient ambulation, and daily mouth rinse • Ongoing SPS CLABSI standard and recommended bundle elements <p>Sustainment Strategy: Ongoing consistent BBAM protocol.</p> <p>Actively Testing: BMSCH is not actively testing.</p> <p>Additional Information: For outcomes detection, BMSCH uses automated EMR alerts for positive blood cultures that trigger infection prevention</p>

	<p>review. They have implemented all standard and recommended bundle elements house-wide.</p> <p>EMR: Epic</p>
<p>Cohen Children's Medical Center of NY</p> <p>Stephanie Fabig, fabig@northwell.edu</p> <p>James Schneider, JSchneide2@northwell.edu</p> <p>Christine Marigliano, CMarigli@northwell.edu</p> <p>Sharon Goodman, Sgoodman3@northwell.edu</p>	<p>Top Interventions: Cohen Children's Medical Center of NY (Cohens) interventions include: High-risk bundle, leadership and champion engagement, and real-time communication.</p> <p>Sustainment Strategy: Pre-occupation with failure and constantly aiming to outperform, constant re-education on bundle, maintained efforts in sustaining champions within each unit and holding monthly champion meetings.</p> <p>Actively Testing: Cohens is actively testing the review of bundle element adherence in units hospital-wide on a regular basis. They also conduct Electronic Medical Record documentation review during RCA.</p> <p>Additional Information: For outcomes detection, Cohens has Infection Prevention review daily lab reports, identify any positive blood cultures, conducts investigation, enters information into RedCap, and shares with the affected unit. An RCA is then conducted with a multidisciplinary team to review. Cohens has implemented all standard and recommended bundle elements hospital-wide.</p> <p>EMR: Sunrise</p>
<p>The Children's Hospital of San Antonio</p> <p>Kelly Kamiya, kelly.kamiya@christushealth.org</p> <p>Stephanie Anguiano, stephanie.anguiano@christushealth.org</p> <p>Maritza Seineke, maritza.seineke@christushealth.org</p> <p>Crystal Stricklin, crystal.stricklin@christushealth.org</p> <p>Monica Pierce-Charlton, monica.piercecharlton@christushealth.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Team education/engagement • Increased auditing • Dedicated workspace for accessing lines <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Continuous monitoring • Reporting data at unit-based council meetings • Celebrating team accomplishments <p>Actively Testing: The Children's Hospital of San Antonio (CH of SA) is actively testing hand hygiene audits before and after a meal (lunch) and daily shower/bed bath audits.</p> <p>Additional Information: For outcomes detection, CH of SA uses audit tools, event reporting, and Infection Prevention event alerts.</p> <p>They have implemented all standard and recommended bundle elements house-wide. However, the hospital clarifies that they do not perform daily CHG treatments with 2% wipes on patients with contraindication to CHG.</p> <p>EMR: MediTech and Athena</p>

Employee/Staff Safety (ESS)

Content highlighted below speaks to efforts related to overall Employee/Staff Safety improvement (Days Away, Restricted or Transferred - DART) as well as improvement in specific harm areas of Overexertion (OE) and Patient Behavioral Events (PBE).

Hospital & Contact Info	Best Practices & Highlights
<p>Akron Children’s Hospital</p> <p>Kathy Stoner, kstoner@akronchildrens.org</p>	<p>Employee/Staff Safety Highlight: Days Away, Restricted or Transferred (DART) & Patient Behavioral Events (PBE)</p> <p>Top Interventions:</p> <ul style="list-style-type: none"> • Hospital leadership commitment • Increasing acceptance of behavioral personal protective equipment (BPPE) and the general need to be better prepared when encountering patient aggression <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Collaboration with the Change Management Team to understand acceptance and craft plans to educate and support local teams with continued follow-up • Ongoing visibility of efforts toward system-wide risk assessments with intervention plan if positive risk screening • Behavioral Response Task Force allows for multi-pronged approach with a number of behavioral efforts <p>Reasons for Success: Akron Children’s Hospital (Akron Children’s) has built a culture that prioritizes ESS by having conversations at all levels to increase visibility of the problem and efforts being made. They also integrate this strongly into broader Safer4All education and messaging throughout the organization.</p> <p>Outcomes: The hospital has organizational goals to reduce employee harm (DART) and PBE.</p> <p>The Medical Director for Patient & Staff Safety leads this work, although it is a multi-disciplinary effort.</p> <p>At Akron Children’s, their greatest focus to date has been on the highest-risk areas (Emergency Departments, Adolescent Unit, Behavioral Health Units), although they are now working to spread to additional locations such as PICU and Urgent Cares.</p> <p>Communication: Those that see local DART data are the Patient Interaction Committee, Safety Steering Committee, and Hospital Acquired Conditions Committee, which all receive regular report-outs. DART data is</p>

	<p>also a factor for the Workplace Violence Committee, which reports to the Workplace Violence Advisory Council, the Quality Committee of the Board of Directors, and the full Board of Directors.</p> <p>To share information about local PBE improvement efforts, Akron Children’s uses intranet communications, multiple additional forums (e.g., hospital-based cluster meetings, departmental meetings where relevant, and RCA sharing at quarterly Grand Rounds). They state there is also opportunity for them to share more consistently.</p> <p>Barriers: The hospital states that serious physical harm events are easier to track, as they result in DARTs or TRIRs, while the less physical serious harm and psychological harm events are more challenging to track. Currently, Akron Children’s relies on local areas to raise concerns when staff are overwhelmed, or the safety team contacts local leaders when events arise where the emotional well-being of staff is of concern. They routinely refer these areas to a Critical Incident Support Team (CIST) for intervention. Additionally, any staff involved in an RCA is automatically referred to CIST (there have been 3 PBE-related RCAs in 2023).</p>
<p>Children’s Healthcare of Atlanta</p> <p>Sara Green, sara.green@choa.org</p> <p>Maggie Johnston, Maggie.Johnston@choa.org</p> <p>Rachel Brooker, Rachel.Brooker@choa.org</p>	<p>Employee/Staff Safety Highlight: Days Away, Restricted or Transferred (DART) & Patient Behavioral Events (PBE)</p> <p>Top Interventions:</p> <ul style="list-style-type: none"> • Workplace Violence Guiding Team (WPV) – Executive leadership involvement in collaborative efforts towards identifying and resolving workplace safety-related issues • Unified training approach to preventing employee harm before it occurs through utilizing the Marcus Crisis Prevention Program (MCPV) • Tracking WPV events and making individual outreaches to involved employees <p>Sustainment Strategy: Children’s Healthcare of Atlanta (Children’s Atlanta) has a dedicated team and resources to continue training. Additionally, they have a cultural focus on reducing serious employee harm as well as continued executive-level support of the WPV Guiding Team.</p> <p>Reasons for Success: Children’s Atlanta believes the following factors have contributed to their success:</p> <ul style="list-style-type: none"> • Emphasis on training Patient Safety Supporters as first-line of care for patients with behavioral and mental health needs • Security leadership driving an enhanced strategic approach with system support that is impacting the care environment and staff safety culture • System recognition and training prioritization for Assistant Nurse Managers as front-line patient care providers and leaders

	<p>The hospital has built a culture that prioritizes ESS by having a system that emphasizes the importance of transparent two-way communication at all levels. This hospital also recognizes the importance of having leader-level support in identifying and advocating for the resources needed to reduce serious employee harm and having executive-level support to consistently respond to workplace safety events.</p> <p>Outcomes: The hospital is strategically targeting PBEs including all Workplace Violence (WPV), sharps, and bloodborne pathogen exposures.</p> <p>In this hospital, those that are involved with leading and operationalizing efforts to reduce DART are the WPV Guiding Team, Employee Health, and Safety.</p> <p>Children’s Atlanta’s ESS DART improvement work is house-wide as all employees participate in various learning opportunities. Learning modalities include virtual learning, in-person didactic, and hands on skill building. The hospital states their promise is “people first, children always” and the safety of employees, patients, and families is of the utmost importance.</p> <p>Communication: Those that see local DART data are Worker’s Compensation and Employee Health, who receive the data and disseminate it to departments and teams that are working on relevant initiatives.</p> <p>Barriers: Based on the fast-paced nature of job duties, employees may miss or delay reporting workplace injuries. Children’s Atlanta is working to change the culture of reporting incidents in real-time by working with departments to encourage reporting and streamlining the reporting process.</p>
<p>Cook Children's Medical Center</p> <p>Jenny Riddle, Jenny.riddle@cookchildrens.org</p>	<p>Employee/Staff Safety Highlight: Days Away, Restricted or Transferred (DART) and Overexertion (OE)</p> <p>Top Interventions:</p> <ul style="list-style-type: none"> • Hiring of Occupational Health (OH) Manager role to oversee and collaborate with Quality for three ESS Cohorts. OH Manager and Quality representative co-lead ESS cohort committees • Patient handling risk assessment (development) integration within EMR • Behavioral risk screening tool embedded in EMR with patient-specific care plan • Hiring of an Athletic Trainer to round on, coach, and educate Environmental Services (EVS) and clinical staff <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Increased involvement of executive leaders and directors at the microsystem level

- Movement toward proactive safety tools, learning teams, safety huddles, and leader rounding
- Development of dashboards to monitor engagement in safety interventions
- Unit-level safety champions
- Discussion to review potential injuries and mitigations strategies at unit level quality and staff meetings

Reasons for Success: Cook Children's Medical Center (Cook Children's) believes the following factors have contributed to their success:

- Overexertion rounding
- One-on-one coaching with the Athletic Trainer
- Behavioral Emergency Response Team with proactive rounding
- Behavioral Health Oversight Committee
- Link in EMR to patient handling site with tools, videos, and helpful forms
- New Pilot: Patient handling and mobility champions

Cook Children's has built a culture that prioritizes ESS by:

- Introducing employee harm at orientation and stressing the need to report events
- Hosting discussions/opportunities at unit-level quality meetings
- Electronic injury reporting form requires supervisor response, which allows the supervisor manager and director to take ownership of employee safety and mitigation strategies at the unit level

Outcomes: This hospital has a 2024 strategic goal to continue to capture and analyze system-wide employee safety data and deploy ongoing injury prevention strategies. Cook Children's is strategically targeting Overexertion (OE), Slips/Trips/Falls (STF), and Patient Behavioral Events (PBE).

In this hospital, leading and operationalizing efforts to reduce DART involve:

- Strong CEO, executive leadership, and board support
- Quality improvement department in collaboration with OH to co-lead the hospital's ESS teams for PBE, OE, and STFs
- Executive leaders who have partnered with directors of microsystems, Quality department and OH for SPS OE Improvement Cohort

This hospital's ESS DART improvement work is house-wide with the Overexertion pilot focusing specifically on their surgical unit.

Communication: Those that see local DART data include board members and executive leadership, including CEO, CMO & ACO, CQO and CNO. Additionally, the hospital's Patient Safety Committee, Quality leadership, and

	<p>OH leadership review the data. Individual ESS cohort project committees review monthly. The Environment of Care Meeting reviews quarterly.</p> <p>To inform employees about data and improvement efforts, Cook Children's takes the following actions:</p> <ul style="list-style-type: none"> • Total numbers included on a patient safety dashboard available hospital-wide and reports monthly in patient safety committee • Total numbers included in board committee monthly report • EVS injuries discussed at EVS staff meetings along with mitigation strategies • Monthly report at PBE committee and OE committee meetings. Reports include nature of injury and potential mitigation/prevention strategies, lessons learned, and discuss process changes • Daily safety briefing call includes daily report of any ESS injuries and DART injuries <p>Barriers: The hospital reports that staff are sometimes hesitant to report injuries, and the event reporting system is separate from the injury reporting system. Close partnership between Quality and OH supports reporting injuries to SPS.</p>
<p>Helen DeVos Children's Hospital</p> <p>Jen Liedke, jennifer.liedke@helendevoschildrens.org</p>	<p>Employee/Staff Safety Highlight: Patient Behavioral Events (PBE)</p> <p>Top Interventions:</p> <ul style="list-style-type: none"> • Leadership support has been a significant part of the success of their workplace violence initiatives. They state there have been continuous review of the effectiveness of active initiatives as well as gaps that could require further improvement work • Helen DeVos Children's Hospital (HDVCH) implemented a cohort of behavioral health patients on specific units, have provided their staff with additional training in the care of this patient population, and have ensured that Security Services are in the vicinity when appropriate <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Continuous review and modification of active initiatives to adjust to the climate of the hospital and review of feedback to understand what is working and where there are still gaps • Rounding with team members to encourage reporting and hear their feedback on what could help <p>Reasons for Success: HDVCH has built a culture that prioritizes ESS as they escalate workplace violence events to the local daily check-in (DCI) and the executive DCI level as needed for awareness and additional support. The Employee Safety Team rounds with the Clinical Team members to ensure that their voices are heard, and that they are receiving appropriate support and resources.</p>

	<p>Outcomes: Workplace violence is a strategic initiative for the Corewell Health West Employee Safety Team.</p> <p>The Security Team is responsible for the overarching system workplace violence program and the Employee Safety Team partners with Clinical Teams to implement strategies that assist team members with prevention, intervention, and recovering from workplace violence events.</p> <p>The improvement at HDVCH is spread house-wide.</p> <p>Communication: Local PBE DART data is shared with the Leave Administration Benefits Administrators, who have access to all the PBE DART data for the system through their third-party administrator (Sedgwick). The director-level leaders at HDVCH have a dashboard within their event reporting system that allows them to review data related to workplace violence events that occur.</p> <p>To inform employees about local PBE data and efforts, the workplace violence incidents are reported at the hospital's daily check-in (DCI) meeting and there is an active SharePoint site where all active initiatives and resources can be accessed by team members and leaders. This data is also shared at a variety of meetings, including the Environment of Care meeting for the area, Clinical Assembly, Harm Collaborative, and various other meetings. The information shared includes the location, the type of violence (physical, verbal, sexual), if there were any injuries requiring treatment, and if security was involved, as well as any active initiatives being implemented to prevent further incidents.</p> <p>Barriers: HDVCH states their largest barrier is needing to reinforce the culture of reporting, as historically team members have felt that many aspects of workplace violence are part of their job and do not warrant reporting. The Employee Safety Team actively works to educate team members on the benefits and importance of reporting through rounding and working directly with clinical leaders and team members after a workplace violence event has occurred.</p>
<p>UH/Rainbow Babies & Children's Hospital</p> <p>Joyce Deptola, Joyce.Deptola@UHhospitals.org</p> <p>Andrew DeLong, Andrew.Delong2@UHhospitals.org</p>	<p>Employee/Staff Safety Highlight: Patient Behavioral Events (PBE)</p> <p>Top Interventions:</p> <ul style="list-style-type: none"> • Addition of a trained behavioral specialist assigned to the medical unit where patients with behavioral concerns receive care. This full-time employee assists with care planning and conducts proactive huddles with staff to ensure situational awareness and planning for potential risks

- Implementation of Welle de-escalation training across the hospital, which has greatly improved staff's response to escalation behaviors and reduced patient meltdowns that lead to injury
- Addition of a dedicated security officer who is assigned to the medical unit where these patients receive care

Sustainment Strategy: UH/Rainbow Babies & Children's Hospital (Rainbow) launched an Interdisciplinary Behavioral/Mental Health Clinical Effectiveness Team to establish evidence based (or informed) care guidelines across their pediatric system of care and are partnering with local community resources, Department of Children and Family Services (DCFS), and others to identify opportunities to avoid unnecessary hospitalizations for the behavioral population that are often admitted without a true medical indication.

Reasons for Success: Rainbow has built a culture that prioritizes ESS, as their staff were very vocal and appropriately demanded leadership attention on this issue. Leadership has demonstrated 100% commitment to supporting the financial costs of additional FTE resources, training expenses, and ongoing improvement efforts to keep staff safe.

Outcomes: ESS is included in the organization's top quality and safety strategies for the organization with metrics of DART, TRIR, and frequency of workplace violence events on the hospital-wide scorecard. They've intertwined ESS work with the system's workplace violence efforts so PBEs have escalated to a top priority in employee harm efforts.

In this hospital, those that are involved with leading, operationalizing, and executing ESS improvement include:

- Director of Quality and Safety, who has primary responsibility for these improvement efforts and partners closely with the CEO and Chief Safety Officer to address issues related to staff security
- Chief Nursing Officer, who is responsible for coordinating specific efforts to improve safety for employees who care for the behavioral population (PBE)

Rainbow's improvement work has focused on the inpatient medical unit where the behavioral population often receives care, but the hospital has spread WELLE training, behavioral carts (including tablets, headphones, weighted blankets, fidget toys for patient use) and behavioral personal protective equipment (BPPE) carts (containing protective sleeves, helmets, face shields) to the emergency department, as well as operative and procedural locations.

	<p>Communication: Local PBE DART data is shared at their local workplace violence taskforce each month and distributed via email to local leaders for review. Additionally, data is shared as part of the hospital-wide scorecard, which is distributed monthly to all managers and above and is shared at the Quality and Safety Council Meeting, Medical Executive Meeting, and Hospital Board Meeting. Information is also discussed in safety rounds on the division.</p> <p>Barriers: Rainbow states that employees working with this population initially felt that incurring injury was part of “the job” but with a large amount of effort in 2023 to improve the reporting of employee workplace violence events, they’ve seen marked improvement in reporting, especially from the inpatient psychiatry unit and emergency department. The hospital’s reporting is escalated to leadership through a variety of methods but primarily through the daily organizational safety brief.</p> <p>To resolve these barriers, they executed a hospital-wide campaign in the spring of 2023 to encourage reporting of these events and have seen improvement in employee injury reporting overall. The campaign included signage across the hospital, just-in-time job aids for entering an event into the system, the inclusion of workplace violence events in unit safety huddles, and monitoring days since last at the top of their daily safety brief.</p> <p>Now, they capture data from a variety of sources including the event reporting system, employee health injury reports, and code violent event records that are captured by their police department.</p>
<p>University of Rochester Medical Center - Golisano Children’s Hospital</p> <p>Rebecca Kanaley, Rebecca_Kanaley@urmc.rochester.edu</p> <p>Amy Keller, AmyR_Keller@urmc.rochester.edu</p>	<p>Employee/Staff Safety Highlight: Patient Behavioral Events (PBE)</p> <p>Top Interventions:</p> <ul style="list-style-type: none"> • Admission aggression risk screen and order set • Specialized consult team (Intensive Behavior Team) • Crisis Prevention Institute (CPI) training for staff • System-wide culture change that paves the way for other supports and resources to prioritize this work <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • The University of Rochester Medical Center - Golisano Children's Hospital (URM-Golisano) Complex Behavior Leadership Steering group meets regularly to review and strategize ongoing interventions/current clinical needs • Having multiple interdisciplinary team members embedded across every unit, including senior leaders and behavioral health champions <p>Reasons for Success: URM-Golisano states they have found success listening to their nurses and taking the time to build out their comprehensive</p>

system step-by-step. They state they got creative with resources and focused on training and capacity building.

The hospital has built a culture that prioritizes reducing PBEs by having an interconnected, comprehensive system of support to establish the most effective and robust process to support patients and staff. Furthermore, the hospital states that Error Prevention training and an ongoing emphasis on its principles supports a culture of safety and the importance of reporting events to facilitate learning and inform future improvement interventions.

Outcomes: Reduction of both overall DART and PBE events are metrics closely followed on the annual University of Rochester Medical Center (URMC) Quality Assurance Performance Improvement dashboard, which is reported out to URMC leadership quarterly.

In this hospital, those that are involved with owning and executing PBE harm reduction are:

- Senior Clinical Nurse Leader for Quality and Safety
- Nurse Manager of General Care Unit, Adolescent Medicine/Hospital Medicine/Trauma
- Director of the Intensive Behavior Team

Executive sponsors who provide oversight include:

- Chief Clinical Officer and Associate Chief Clinical Officer
- Chief Nursing Officer
- Chief Quality Officer

Improvement is house-wide on all inpatient units.

Communication: For local PBE DART data, all owners/executors and executive sponsors receive and see the data at least monthly. Individual unit DART and specifically PBE are included on the hospital's monthly quality dashboard for each unit, which is shared with local leaders, safety nurses, and senior hospital leadership for dissemination.

Barriers:

- Numerator: Having an automated report that includes both the employee department and children's hospital event location with a duplicate report run at the end of each month for DART data accuracy
- Denominator: Defining who children's hospital employees are. The hospital combines a monthly hours worked report with a standard FTE count for shared departments

Falls

The following hospitals report that they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Children's Hospital of Illinois at OSF Healthcare</p> <p>Jessica Doyle, Jessica.A.Doyle@osfhealthcare.org</p> <p>Amanda LeSage, Amanda.L.LeSage@osfhealthcare.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Usage of the Humpty Dumpty fall risk assessment tool • Use of fall prevention signs • Utilization of play mats • Parental engagement - education and parent partnership forms that legal guardians sign upon admission • Safety sweeps are performed three to four times per day • Review of all fall events that occur to identify gaps in care and develop action items to prevent future falls <p>Sustainment Strategy: Continuous education with staff regarding fall prevention education, holding debriefs after a patient fall, and then re-sweeping high fall-risk patients.</p> <p>Actively Testing: Children's Hospital of Illinois at OSF Healthcare (CHOI) is not actively testing.</p> <p>Additional Information: For outcomes detection, fall events are documented in the EMR which triggers an automatic event to the event reporting system for falls occurring on the unit. When an event occurs off unit, the charge nurse enters a safety event for the fall.</p> <p>CHOI has implemented all standard bundle elements. Of the recommended elements, the hospital implements:</p> <ul style="list-style-type: none"> • Utilization of 1:1 sitter for some higher fall-risk patients who do not weigh enough for the bed/chair alarms to work optimally or on patients who are impulsive • Utilization of the expectation that high fall-risk patients are not allowed to go to the bathroom alone; they must be escorted by an employee to and from the bathroom and must stay in the bathroom with the patient • Hourly rounding completed 0600-2200 and every two hours from 2200-0600 <p>All standard and listed elements are used primarily on the following units: Pediatric Intensive Care, Pediatric Intermediate, General Pediatrics, and Pediatric Hematology and Oncology.</p> <p>EMR: EPIC</p>
<p>Nicklaus Children's Hospital</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Embedded in organization culture with every patient scored every shift • ACA and GEMBA walks are conducted with interdisciplinary HAC Team for all falls with harm and as needed

<p>Deborah Hill-Rodriguez, deborah.hill-rodriguez@nicklaushealth.org</p> <p>Jenna Lang, jenna.lang@nicklaushealth.org</p>	<ul style="list-style-type: none"> • Every event that occurs organization-wide is reviewed at the unit level with the involved staff member and the follow up is discussed with the Falls HAC Team <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Continual awareness and review of events by interdisciplinary team • Embedded in education throughout organization onboarding and annually • Partnering with families on falls safety (in welcome video that must be watched by all families, and in Hand in Hand Together We Can Tool used for parents at the bedside) • Falls HAC champions completing monthly auditing organization-wide <p>Actively Testing: Nicklaus Children's Hospital (Nicklaus Children's) is actively testing:</p> <ul style="list-style-type: none"> • Revision of falls scale (Humpty Dumpty) is currently in a multi-site study • Incorporation of Humpty Dumpty in discharge planning to transition patients to home (Humpty's Heading Home) <p>Additional Information: For outcomes detection, Nicklaus Children's uses the Humpty Dumpty falls scale assessment tool to alert to high/low risk protocol, events are captured through incident reports, and there is review of all events through the Falls HAC Team bi-weekly.</p> <p>They have implemented all standard bundle elements and specific mitigation strategies for patients at risk for falls within injury from the recommended elements. These elements are implemented organization-wide, including in inpatient areas, ambulatory areas, urgent care areas, Emergency Department, radiology, surgical services, and rehabilitation services.</p> <p>EMR: Cerner</p>
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Venous Thromboembolism Event (Non-CVC VTE)

The following hospital reports they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Children's Hospital of Philadelphia</p> <p>Orysia Bezpalko, BEZPALKOO@chop.edu</p> <p>Rachel Ponzek, PONZEK@chop.edu</p> <p>Stephanie Powell, POWELLS@chop.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Ability to accurately identify all thrombotic events • An electronic health record clinical decision support tool was built to produce a "VTE Individual Risk Factor Report" that informs the nurse of the clinical risk factors for VTE for their patient. The clinical decision support tool pulls from the daily nursing documentation to inform the nurse of the clinical risk factors for VTE for their patient • In addition, they created a Best Practice Alert to inform clinicians of the patient's VTE risk and what is needed to prevent harm

<p>Heather Giardino, STEWARTH@chop.edu</p>	<ul style="list-style-type: none"> VTE Prevention Committee that includes representation from every inpatient unit who serve as champions for VTE prevention. These representatives provide integral feedback about the true state of Children's Hospital of Philadelphia's (CHOP) harm prevention efforts on the inpatient units - they have been drivers of significant changes in this hospital's approach through the years <p>Sustainment Strategy: CHOP sustains successes with a VTE Prevention Committee and leader rounding on inpatient units.</p> <p>Actively Testing: CHOP is not actively testing.</p> <p>Additional Information: For outcomes detection, CHOP uses a combination of methods to detect events including Natural Language Processing of all imaging reports to identify when thrombotic events occur combined with ICD-10 thrombosis codes at discharge. The hospital implements all standard bundle elements hospital-wide.</p> <p>EMR: Epic</p>
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Pressure Injury (PI)

The following hospital reports they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Cohen Children's Medical Center of NY</p> <p>Stephanie Fabig, sfabig@northwell.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> Dedicated Pressure Injury Prevention Specialist/CWCN Active surveillance Enhancing culture through focusing on psychological safety to reporting any level of a pressure injury event <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> Continue to celebrate victories Directed focus on events with high incidence and high actionability Continue to promote a culture of event reporting and/or escalation of any stage, especially of patients with deeper pigmentation, lacking redness as first sign of skin tissue injury TEAM-based versus "siloed" approach, including detailed, actionable elements for the various disciplines <p>Actively Testing: Cohen Children's Medical Center of NY (Cohen) is actively testing.</p> <ul style="list-style-type: none"> Use of "I SEE R.E.D.D.D." tool designed to create consistent PIP and identification and escalation regarding use of medical devices Adherence to process/resource for identification of patients at high risk for BIPAP mask related pressure injury NICU educators do "CARE ROUNDS" – assess care of patients with CPAP Audits of compliance on the use of internal guides related to prevention of respiratory device related pressure injuries

	<p>Additional Information: For outcomes detection, Cohen uses a combination of methods to detect events including:</p> <ul style="list-style-type: none"> • Active surveillance through CWCN, unit leaders, and frontline staff communicating in real time using Microsoft Teams • Improved culture of voluntary event reporting at any time/day into internal reporting platform, iNorth, triggering multilevel and interdisciplinary support from unit leadership to C-suite. Pressure Injury co-leads as well as unit leadership evaluate reports to determine validity of reported event <p>The hospital has implemented all standard and recommended bundle elements house-wide, including perioperative areas, with particular focus on the “rotation of medical devices” bundle element.</p> <p>EMR: Sunrise</p>
<p>Yale New Haven Children’s Hospital</p> <p>Lauren Edwards, Lauren.Edwards@ynhh.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Utilizing the appropriate surface (gel pads/fluid positioners) under occiput for patients with limited ability to turn (e.g., ECMO) • Collaboration with Respiratory Therapy to ensure proper fit of respiratory devices and utilization of device padding (e.g., barrier under BiPAP mask, nasal CPAP) <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Recurring education to staff on the bundle • Utilization of resources for taking a proactive approach (e.g., Would Care Nurses) • Ensuring appropriate products are available • Distribution of a quarterly prevalence survey <p>Actively Testing: This hospital is not actively testing.</p> <p>Additional Information: For outcomes detection, Yale New Haven Children’s Hospital (Yale) uses a dashboard (data source: EMR nursing documentation) as well as a daily report that identifies current pressure injuries (data source: EMR)</p> <p>The hospital has implemented all standard and recommended bundle elements house-wide.</p> <p>EMR: Epic</p>
<p>Randall Children's Hospital at Legacy Health</p> <p>Meg Berkson, mberkson@lhs.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Assessment techniques for darker skin tones, including use of increased lighting • Pressure redistribution surfaces with alternating pressure/microclimate pumps for all areas caring for adolescent patients • Drill downs on all stages of PIs for learnings <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Vigilance, visual management, and sharing learnings from all drill downs with teams • Monthly rounding with skin champions and interdisciplinary team (Leadership, Quality, Wound RN, RCP, and OT/PT)

	<p>Actively Testing: Randall Children's Hospital at Legacy Health (Randall Children's) is actively testing targeted observational audits on the highest-risk patients on each unit.</p> <p>Additional Information: For outcomes detection, Randall Children's uses Patient Safety Reports (PSAs) and monthly skin rounds. Additionally, certified Wound RNs report PIs based on inpatient consults/assessments (staging validated with two RNs for interrater reliability).</p> <p>The hospital has implemented all standard bundle elements house-wide. Of the recommended elements, they implement the following on all units:</p> <ul style="list-style-type: none"> • Scalp assessment, including under braids /ponytails • Devices padded/positioned appropriately • Alternate CPAP/BIPAP masks as able • Offloading of RT tubing/straps Q4 hours • Use of pressure redistribution mattress for all adolescents <p>EMR: Epic</p>
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Surgical Site Infections Legacy (SSI)

The following hospitals report that they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Arnold Palmer Hospital for Children</p> <p>Jill Dykstra-Nykanen, jill.dykstra-nykanen@orlandohealth.com</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Participation in SPS COLO/REC SSI Reduction Pilot • Implementation of a Neurosurgical SSI Reduction bundle for any craniotomies, shunts, etc. • Strict adherence to antisepsis protocol for patients over the age of 12 (modified for patients under the age of 12) • Monitoring of antibiotic choice and timing pre-operatively <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Close observation to process metric tracking with targeted education if needed • Antimicrobial stewardship-stopping antibiotics when no longer indicated to reduce the chance of resistance • Hand hygiene compliance monitoring <p>Actively Testing: Arnold Palmer Hospital for Children (APH) is not actively testing.</p> <p>Additional Information: For outcomes detection, APH uses Epic and Vigilanz to identify potential SSIs. The hospital has implemented all standard and recommended bundle elements house-wide.</p> <p>EMR: Epic</p>
<p>Valley Children's Hospital</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • High adherence rate to bundle compliance

<p>Raed Khoury, rkhoury1@valleychildrens.org</p>	<ul style="list-style-type: none"> • Additionally monitoring and maintaining peri-operative patient normothermia <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Maintaining bundle compliance • Thermoflect Cap usage • Utilizing the symbiotic relationship between the interventions/collaboration with surgical services through the American College of Surgeons National Surgical Quality Improvement Program and SPS <p>Actively Testing: Valley Children's Hospital (Valley Children's) is actively testing the use of Thermoflect Cap and is monitoring as an intervention to maintain peri-operative patient normothermia.</p> <p>Additional Information: For outcomes detection, Valley Children's uses EMR Trigger Alerts: readmissions, return to OR, diagnosis of infection, antibiotic orders, and positive laboratory micro results.</p> <p>The hospital has implemented all standard bundle elements and normothermia monitoring from the recommended elements in the surgical service line and house-wide.</p> <p>EMR: Epic</p>
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Unplanned Extubations (UE)

The following hospitals report that they have high confidence in their outcomes detection.

Hospital & Contact Info	Best Practices & Highlights
<p>Children's Hospital of Wisconsin</p> <p>Khris O'Brien, KOBrien@childrenswi.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Implementing and reinforcing use of the airway guardian • Standardized taping methods and documentation of Endotracheal Tube (ETT) placement • ETT annotation of the chest X-ray tube placement • All of the above are reinforced via policy and procedure <p>Sustainment Strategy: In the NICU, Children's Hospital of Wisconsin (Wisconsin) has improved their 2022 rates; in the PICU they are seeing more unplanned extubations, which is why they plan to start ETT rounds.</p> <p>Actively Testing: Wisconsin is not actively testing but plans to start ETT rounds in the PICU.</p> <p>Additional Information: For outcomes detection, the hospital has four methods from which their team is alerted to UE events:</p> <ul style="list-style-type: none"> • Event reports, self-reported by those involved • Epic trigger from the Endotracheal tube (ETT)/ Lines Drains Airway (LDA) charting being completed with a reason of unplanned • Epic trigger from a note type "unplanned extubation"

	<ul style="list-style-type: none"> • Post huddle form emailed to the UE Team email folder <p>The hospital has implemented all standard bundle elements and the following recommended elements house-wide (except in the operating room):</p> <ul style="list-style-type: none"> • Standardized reference points and securement • Implemented protocol for high-risk situations (airway guardian) • Multidisciplinary ACA form for each event (post event huddle form) <p>EMR: Epic</p>
<p>Hassenfeld Children's Hospital at NYU Langone</p> <p>Rebecca Malizia, Rebecca.Malizia@nyulangone.org</p> <p>Heda Dapul, HedaMarie.Dapul@nyulangone.org</p> <p>Elizabeth Haines, elizabeth.haines@nyulangone.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Implementing the bundle elements, which included a comprehensive educational campaign regarding risk factors and rationale behind bundle elements • Engaging all stakeholders in this work – physicians, nurses, and most importantly, respiratory therapists • Frequent auditing of the bundle elements, both static and dynamic <p>Sustainment Strategy:</p> <ul style="list-style-type: none"> • Constant education and re-education of staff • UE Boot camp for RNs and RTs • Continued reassessment of UE risk factors based on apparent cause analyses of all events <p>Actively Testing: Hassenfeld Children's Hospital at NYU Langone (NYU) is actively testing using a PDSA cycle in the PICU to test standardization of chest x-ray (CXR) positioning. They are currently evaluating CXR quality, as well as auditing the use of the job instruction sheet for patient positioning during chest X-rays.</p> <p>Additional Information: For outcomes detection, NYU uses the patient safety intelligence (PSI) system to report UE events.</p> <p>The hospital has implemented all standard bundle elements and both recommended elements (ACA and twice daily discussion of extubation readiness) in the ICUs (NICU, PICU & CICU).</p> <p>EMR: Epic</p>
<p>Johns Hopkins Children's Center</p> <p>Meghan Bernier, mbernie2@jhmi.edu</p> <p>Stephanie Morgenstern, smorgen2@jhmi.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Structurally: <ul style="list-style-type: none"> ○ Johns Hopkins Children's Center (JHCC) states they have a stable multidisciplinary team (including dedicated project management leadership, hospital and unit leadership, nursing leadership, bedside nursing staff, respiratory therapy leadership, unit champions, and bedside RT, fellowship trainees) of workgroup members who are consistently involved in this work with little turnover in staff members

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- Hospital and unit leadership actively and visibly support the UE work. The UE workgroup is also made visible across the organization because it is embedded into certain strategic priorities, discussed in hospital-wide meetings, etc.
- They have standardized the process each month for meeting preparation, facilitation and follow up. This, coupled with clear roles (e.g., who is doing the chart review before the meeting), has maximized efficiency, and helped those involved anticipate what they can expect
- Those outside of the core UE workgroup are also involved in helping identify and analyze UE events (e.g., the safety specialist who reviews incident reports flags them as UEs for them)
- Clinically:
 - UE prevention bundle elements are integrated into patient care, discussed daily on patient rounds, and have simply become the way work is achieved. This includes standardized Endotracheal Tube (ETT) taping with diagrams and supplies readily available, two clinicians present for diagnostic studies or patient movement, and defined sedation level goals with amelioration orders pre-defined
 - Monthly bedside bundle audits, bringing the focus on prevention to the bedside staff

Sustainment Strategy:

- Planned ahead for fellow transition and allowed a period of overlap during the handoff
- Completed their annual review of JHCC PICU/PCICU and NICU UE bundles to incorporate lessons learned from the previous year

Actively Testing: JHCC is actively testing sticky notes in the EMR for shared visibility across care team members if the patient has had a UE (NICU only). They are also testing standardizing radiology as a core workgroup discipline and trialing SonarMed devices.

Additional Information: JHCC uses the following methods for outcomes detection:

- Reporting through the incident reporting system
- A dashboard that pulls documentation of “unplanned extubation”, “unintended extubation” and “UE”
- Automated email alerts triggered by in-room emergency button (“code”) push by staff members with free text responses indicating whether a UE was involved in the event
- Post-UE surveys as QR codes posted across the unit
- Heightened awareness across all hospital champions to ensure that if they are notified of a UE, they communicate it to the UE workgroup

The hospital has implemented all standard bundle elements house-wide, including 1) standardized anatomic reference points and securement methods and 2) protocol for high-risk situations. Of the recommended elements, JHCC implemented Multidisciplinary Apparent Cause Analysis, and is currently

	<p>implementing Active Discussion on Extubation Readiness via the ICU Liberation Working Group which shares team members with the UE working group.</p> <p>EMR: Epic</p>
<p>Rady Children's Hospital - San Diego</p> <p>Laurel Moyer, LMoyer@rchsd.org</p> <p>Caitlin Gasque, cgasque@rchsd.org</p> <p>Quinn Allen, gallen@rchsd.org</p>	<p>Top Interventions: Rady Children's Hospital - San Diego (Rady Children's) reviews each event at a monthly interdisciplinary meeting with event review led by the physician champion for the unit. With the information from ACA's, they have a pareto for each unit that highlights the contributing factors by each unit and targets interventions if they see an uptick in events.</p> <p>Sustainment Strategy: Continued engagement from physicians, nursing and RT helps to sustain and work towards zero.</p> <p>Actively Testing: Rady Children's states their PICU and CTICU events are quite infrequent, so they are mostly in sustain mode. They have seen a recent increase in NICU events related to retaping and have brought back in-person RT education sessions where there are retaping sessions to ensure that they continue to have standardized approach to taping ETT in the NICU.</p> <p>Additional Information: For outcomes detection, Rady Children's has a safety report that includes the completed ACA during the shift for each event as well as an EMR report that is sent daily with any unplanned extubations. They state they are confident that they are capturing all UE events with the added EMR report, and not only relying on the safety reporting system and ACA completion.</p> <p>The hospital has implemented all standard bundle elements and both recommended elements (ACA and twice daily discussion of extubation readiness). These elements are implemented house-wide in their intensive care units (PICU, CTICU, NICU).</p> <p>EMR: Epic</p>
<p>St. Louis Children's Hospital</p> <p>Carly Wheeler, carly.wheeler@bjc.org</p> <p>Lisa Schuller, lisa.schuller@bjc.org</p> <p>Rakesh Rao, rakesh_rao@wustl.edu</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Standardized anatomic reference point and securement method • Respiratory Therapist role is one of the two required team members for high-risk procedures • Interdisciplinary recognition of loose/unsecured Endotracheal Tube (ETT) as an airway emergency requiring immediate correction <p>Sustainment Strategy: St. Louis Children's Hospital (St. Louis Children's) states they have sustained success through interdisciplinary huddle/time out with role assignment prior to ETT manipulation or re-securement. Additionally, they have the RT Retape Team to hold the ETT during any manipulation or re-securement.</p> <p>Actively Testing: The hospital is actively testing interdisciplinary huddle/time out with role assignment prior to ETT manipulation or re-securement. They also are</p>

	<p>testing a RT Retape Team to hold the ETT during any manipulation or re-securement in addition to airway rounds.</p> <p>Additional Information: For outcomes detection, St. Louis Children's uses the following methods:</p> <ul style="list-style-type: none"> • Submission of a safety event • Submission of a data collection form that is filled out during the multidisciplinary ACA after each event • Identification of any unplanned extubation in the last 24 hours at daily interdisciplinary huddle <p>All standard and recommended bundle elements have been implemented in St. Louis Children's three Intensive Care Units (Neonatal, Cardiac, and Pediatric).</p> <p>EMR: Epic</p>
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Serious Safety Event Rate (SSER)

Hospital & Contact Info	Best Practices & Highlights
<p>Driscoll Children's Hospital</p> <p>Chantel Robling, chantel.robbling@dchstx.org</p> <p>Beth Becker, beth.becker@dchstx.org</p>	<p>Top Interventions: Driscoll Children's Hospital (DCH) states their top reason for success in reducing their Serious Safety Event Rate is superior leadership support. Organizational leaders from the top down have embraced a culture of safety where safety tools are promoted often. They utilize a hospital-wide daily safety huddle and a top 10 list that is actively maintained and updated.</p> <p>Error prevention training is taught by the Quality Department, including senior level management. All the employees within the health system are required to have Error Prevention Training and these tools are reinforced monthly. The Quality Department staff attend all unit staff meetings where they share error prevention tools and safety event reporting information such as actual events and their reporting data. Good catches are celebrated and recognized with safety pins. DCH states that safety is kept at the forefront of all they do.</p> <p>System Changes: DCH revamped their safety event reporting system, reducing the time required to enter an event from 10 minutes to three minutes. They now send an email to every person who has submitted a safety report asking if they would like feedback on their entry (this is not applicable to anonymous reporters). Another system change they incorporated is a link for staff to enter a safety report on the header of their EMR; this allows staff to have multiple options for submission as they try to make the submission process as simple as possible for workers.</p> <p>Key Lessons: The hospital states their biggest lesson learned is that the serious safety event rate is going to increase before it decreases. Do not let this discourage you; trust the process knowing that this is going to be a long journey. At DCH, there is more awareness and additional reporting as personnel become familiar with identifying and sharing near misses and events. These entries hold</p>

<p>Maria Fareri Children's Hospital at WMCHHealth</p> <p>Robin Altman, Robin.Altman@wmchealth.org</p> <p>Sally Umbro, Sally.umbro@wmchealth.org</p>	<p>multiple opportunities for improvement that can lead to an eventual decrease in SSER.</p> <p>Top Interventions: At Maria Fareri Children's Hospital (Maria Fareri), the top reasons they state for success at reducing serious safety events involve the evolution of and achieved prominence of their Safety Event Review Committee that was established in 2019.</p> <ul style="list-style-type: none"> • The hospital recognized quickly that this review process should not be limited to a small committee with a narrow agenda. Over time they expanded membership to include nursing leaders from all units with representatives from pharmacy, respiratory therapy, laboratory, blood bank, and other departments in addition to physician, resident, quality, and risk management leadership • Committee members took ownership for presenting and discussing the events arising from their respective areas. The expectation for this ownership function raised the level of quality of the event reports and led to more robust discussions and greater accuracy in classifying events and in their follow-up • For events requiring deeper review, the committee took on the responsibility of referring them to other relevant hospital committees or hospital-level review systems such as root cause analysis, as appropriate <p>System Changes: Maria Fareri's anonymous electronic safety event reporting system, MIDAS, has played a significant role in reporting, referring, and tracking safety events. Over time, it has been modified and expanded to make it more visible and accessible, more prominent, and more transparent.</p> <p>Key Lessons: Maria Fareri states their key lesson is that event classification and analysis alone are not sufficient to make a lasting reduction on serious safety events. The third essential element, which is potentially the most difficult, is to establish a process for follow-up and feedback that is also transparent. Both the New York State Department of Health and the DNV Healthcare reviewing agency recently recognized their safety event follow-up process as an example of hospital best practice.</p>
<p>Nationwide Children's Hospital</p> <p>Janet Berry, Janet.Berry@nationwidechildrens.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • The Nationwide Children's Hospital Zero Hero safety culture – 14 years strong in 2023 • Robust event reporting with a non-blaming, non-judgmental approach to follow up • An expanding proactive approach to safety (e.g. huddles) including the unique PROMISE program in the CTICU. Published in <i>Congenital:Coronary JTCVS Open, 2022</i> (PubMed Link) <p>System Changes:</p> <ul style="list-style-type: none"> • Nationwide Children's Hospital (Nationwide) has used EMR-integrated sepsis screening, tools, and alerts since 2016

	<ul style="list-style-type: none"> • A predictive analytics model for deterioration, with unique modes for cardiac, oncology, and general patients was implemented in 2020. Published in <i>Pediatrics</i>, 2020 (https://doi.org/10.1542/peds.146.1MA3.229) • They created and utilized a robust M&M system (and database) that acknowledges individual failures but focuses on system issues to improve outcomes. Corrective actions are noted and tracked to completion <p>Key Lessons: The Nationwide Children's Hospital Zero Hero safety culture is intimately woven into their organizational fabric. This starts with Board and Executive Leadership's unwavering support and results in everyone knowing what their role is to contribute to making every day a safe day.</p>
<p>ProMedica Russell J. Ebeid Children's Hospital</p> <p>Cindy Tippett, Cindy.Tippett@ProMedica.org</p> <p>Paula Grieb, Paula.Grieb@ProMedica.org</p> <p>Danielle Sosko, Danielle.Sosko@ProMedica.org</p>	<p>Top Interventions:</p> <ul style="list-style-type: none"> • ProMedica Russell J. Ebeid Children's Hospital (Ebeid Children's Hospital) states they have a robust, multidisciplinary High Reliability Organization (HRO) team that meets weekly to review all incident reports concerning pediatric patients throughout their campus. As a children's hospital within an adult hospital, along with the dedicated children's units, this also includes shared service and outpatient area. Reviewing all events allows them to identify and intervene in those near miss and precursor events that could lead to a serious safety event • Front-line staff are involved in the Cause Analysis process through interviews, assisting with timelines, and having a voice in action plans. In the case of an SSE, once an action plan has been developed, the Quality Manager presents a high-level, de-identified overview to the teams involved. Focus is on the action plan that was developed to prevent future occurrences • Throughout their process they reiterate that this work is done to provide a safe and quality atmosphere for all, patients, staff, and families. The hospital assures staff that this is not a punitive process, and they are not looking to put blame on an individual or group, instead, the focus is on improving the system processes. They iterate that as humans, we can make errors, and are working to develop strong processes to help eliminate errors/occurrences <p>System Changes: Ebeid Children's Hospital uses the EMR EPIC and RL 6 is the web-based tool they use to document incidents and risks. RL 6 is accessible within all patient records through EPIC which allows a simpler, quicker way to complete the incident reports. These reports assist in tracking and trending of events.</p> <p>Key Lessons: Ebeid Children's Hospital shares the following two key lessons they learned during their SSER improvement journey:</p> <ul style="list-style-type: none"> • The follow-up with staff regarding the outcome of Root Cause Analysis or other cause analysis efforts has been a great way to assure staff is involved and aware of what is happening throughout the organization

- They have found that follow-up to ensure action items are completed is very important. The Quality Manager continues to meet with the stakeholders assigned to action items every two to four weeks after initial action planning development until all items have been completed

Ambulatory Safety

Hospital & Contact Info	Best Practices & Highlights
<p>Children's Hospital of Philadelphia</p> <p>Kelly Sweeny, OSHEAKA@chop.edu</p> <p>Rachel Ponzek, PONZEK@chop.edu</p> <p>Maria Mihalko, mihalko@chop.edu</p> <p>Anya Even, EVENA@chop.edu</p> <p>Stephanie Powell, POWELLS@chop.edu</p> <p>Orysia Bezpalko, BEZPALKOO@chop.edu</p> <p>Khoi Dang, DANGK@chop.edu</p>	<p>Ambulatory Journey: To start, Children's Hospital of Philadelphia's (CHOP) enterprise-wide Patient Safety Committee (PSC) leadership championed the formation of a smaller committee reporting to PSC to shine light on the safety efforts and concerns, both patient and employee-related, present in areas external to their inpatient hospitals. The ensuing formative process of the Ambulatory Network Safety Committee (ANSC) helped define the environments for the committee's purview to their Urgent Care centers, Primary Care network, and Specialty Care centers while the behavioral health and ambulatory surgical centers would fall under other sub-committees to PSC. This boundary definition allowed easier identification of provider, nursing, and operational leaders to invite as members of ANSC with the goal(s) of:</p> <ul style="list-style-type: none"> • Advancing the culture of safety across the ambulatory enterprise • Development, trend measurement, and analysis of patient and employee safety data • Review and discussion of safety event analyses and cascading of knowledge gained from committee efforts or presentations <p>With support from their Patient Safety Program's leadership including the Chief Safety and Quality Officer, the Medical Director for Patient Safety, and PS program managers, further advocacy and discussion occurred with leadership from the three ambulatory areas that led to the creation of ANSC. Having previously identified clinical safety leaders in the Primary Care network, their next goal was to advocate for similar interested parties from amongst the provider/nursing/operational leadership in the other two areas (Specialty Care and Urgent Care) via promotion of the benefits of a shared safety culture and group efforts in patient/employee safety.</p> <p>Noting the various departments represented at the larger PSC meeting, ANSC sought to engage with applicable leadership from these departments along with the newly identified ambulatory leaders. These additional departments included Emergency Preparedness, Infection Prevention & Control, Security, IS, Home Care, Employee Health & Safety, and Risk Management to name a few. Further support from the hospital's Patient Safety Team was instrumental in the completion of their initial membership pool.</p> <p>The hospital states they faced the following challenges during their journey:</p> <ul style="list-style-type: none"> • The disparate needs and situations between types of ambulatory locations (Primary Care, Specialty Care, Urgent Care) remains a challenge, but they try to plan monthly discussion topics that are broadly applicable and highlight the areas in which they can learn from each other and expand upon strengths. When needed, they create smaller workgroups for action items that may be more specific to one type of location

- Availability of resources is another challenge that they, like every ambulatory program, continue to face. By creating a comprehensive ambulatory safety structure, choosing engaged and knowledgeable leaders, and capitalizing on efficiencies and synergies with other ongoing work – the hospital aims to reduce silos to maximize the resources available for this very important work

In terms of Health Equity, The Center for Health Equity leadership has presented at the monthly Ambulatory Network Safety Committee with updates about their ongoing work as well as reminders and tips for keeping health equity at the forefront of all safety work. As their Center for Health Equity expands, they plan for more strategic inclusion in safety work across the board, including ambulatory safety.

For structure, CHOP incorporates operations and clinical leaders from ambulatory structures (primary care, specialty care) on the steering committee to strategize the direction of the work for each year. Those leaders are responsible for cascading information and interventions to their teams at all ambulatory locations.

Strategic Priorities: CHOP is currently looking to strengthen their work in Ambulatory CLABSI, along with working to improve ambulatory follow-up adherence (testing, imaging, referral appointments, etc.)

Top Interventions:

- Inclusion of ambulatory events in the patient safety review process (root cause analyses, cognitive systems analyses and apparent cause analyses) with mechanisms to share learnings throughout the enterprise
- Open discussion and story sharing of ongoing ambulatory safety concerns during the monthly ambulatory network safety committee as well as in the overall patient safety committee, and among leaders and team members

Measurement Strategy: In terms of data collection, they utilize the RL safety event reporting system and filter by location type. Additionally, a variety of different dashboards exist, pulling data from both the EHR and event reporting system (vaccine safety, ambulatory falls, etc.) – however their desired future state of ambulatory data is to have a comprehensive ambulatory safety dashboard.

CHOP shares ambulatory event review learnings in the enterprise-wide Patient Safety Committee and in the monthly MM&I forum. De-identified list/themes of ambulatory events are shared with leaders on a monthly basis.

Joe DiMaggio Children's Hospital

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Ambulatory Journey: To start their journey, Joe DiMaggio Children's Hospital (JDCH) developed a steering committee structure and completed the gap analysis which included their hospital-based ambulatory areas and Emergency Services. They also established a committee aligned with their organization's patient safety committee structure and focused the agendas on safety and quality data review, safety event analysis, and cultural improvement projects.

Those involved include:

- Director of Hospital-Based Ambulatory

- Director of Emergency Services
- Manager & Clinical Manager of Hospital-Based Ambulatory
- CMO, CNO, Director of Quality & Safety, Quality Manager – Ambulatory
- Departmental staff
- Champions identified through assessing who was aligned on commitment and who would have impact on making positive change

In terms of challenges, the hospital struggled with deciding on selecting a main goal to support as there were a lot of priorities to consider. They also said developing a team was a challenge since those involved are also involved with many other projects and priorities. Because ambulatory encompasses hospital-based services and outpatient services, there are also various leadership teams involved.

JDCH is collaborating with their Safety Disparities SPS team on health equity. Their system has a “community hub” for referrals of patients who score high-risk for disparities. This is in the process of being implemented at their hospital starting with ambulatory areas. They have also been working with the system office of belonging and equity to align with their priorities.

At JDCH, ambulatory areas are hospital-based and included in safety rounds and daily organizations safety report-outs. They include safety reports during ambulatory meetings and reports to the Performance Improvement Team that is inpatient- and outpatient-based.

Strategic Priorities:

- Implementing screening assessments for recognition of mental and behavioral disorders
- Implementation of screening for disparities for recognition of community hub referrals

Top Interventions:

- Transparency through event reporting/discussion
- Stories/case reports of individual patient harm events
- Empowerment of staff/leaders in reporting – providing a “safe” comfortable environment to report events and supporting them in making positive changes
- Present findings to current quality and safety leader forums and ambulatory leadership

Measurement Strategy: JDCH collects data through a safety event reporting system. Safety events as well as near misses are collected, reviewed, and reported to Quarterly Quality Performance Improvement Committee. They also attend weekly Just Culture meetings for both inpatient and outpatient.

To share stories regarding ambulatory safety across the organization, the hospital does the following:

- Daily organizational/departmental morning huddles
- Quarterly Quality Performance Improvement meeting

	<ul style="list-style-type: none"> • Regularly reported in medical staff department meetings • Weekly Just Culture meetings both inpatient/outpatient • Staff recognition through Patient First Awards • Share stories in newsletters
<p>Stanford Medicine Children's Health</p> <p>Noah Kim, nokim@stanfordchildrens.org</p> <p>Jenna Kruger, Jekruger@stanfordchildrens.org</p>	<p>Ambulatory Journey: Stanford Medicine Children’s Health journey started with establishing an Ambulatory Quality and Performance Improvement (QAPI) Committee in September 2021; prior to that they had a long-standing Operations & Quality meeting that involved all the clinical service chiefs and practice managers.</p> <p>The following played key roles in setting up their quality structure: Quality Improvement Advisor, Associate Chief Nursing Officer, Associate Chief Medical Officer, and the Chief Quality Officer. The champions were chosen based on their close work in quality & Ambulatory leadership.</p> <p>They state their biggest challenge was getting started as the concept was new to ambulatory and they were disconnected from the inpatient QAPI structure. This required a focus on education with all involved on the benefits of having an Ambulatory specific QAPI. They also struggled with ambulatory-wide quality initiatives versus supporting specific specialty-based quality work.</p> <p>New this year, one of their core goals is to focus on health equity for patients, specifically in interpreter services utilization rates. The hospital’s new Chief Quality Officer, who is a member of QAPI, is the organization’s health equity champion, so she will bring a focused lens on health equity in the Ambulatory QAPI.</p> <p>In terms of structure, their various workgroups advance quality improvement efforts that are aligned with the core goals identified each year. These workgroups report into Stanford Medicine Children’s Health’s QAPI, which reports to the Faculty Practice Organization and the Quality and Safety Oversight Committee, up to the Board of Directors.</p> <p>Strategic Priorities: For the past couple of years, Stanford Medicine Children’s Health’s ambulatory-wide goals have centered around hand hygiene compliance and closing out safety event reports in a timely manner. These continue to be a focus moving into FY24, with the addition of influenza vaccination rates and interpreter services utilization.</p> <p>Top Interventions: Stanford Medicine Children’s Health has implemented Standing Orders in seven specialties, allowing the nurses to work to the top of their license, supporting the physicians in spending more time with the patients, and improving workflow of the clinic. At the same time, this adds a layer of patient safety as these standing orders have all been vetted and approved by the physicians, nursing, and the regulatory/compliance partners.</p> <p>They also started a new committee called the Ambulatory Operations New Process Committee which is a multi-disciplinary team approach to reviewing and approving new procedures/projects in the Ambulatory space. The committee approves it and then</p>

	<p>it goes to the CNO & CMO for final approval before implementation, so they are not working in silos.</p> <p>Measurement Strategy: Staff utilizes the safety event reporting system “iCares” to log unusual or unexpected events, near misses, or professional conduct. In addition to location, iCares are categorized into specific event types that fall under larger general event types. iCares are routed to any involved department/location, a subject matter expert, and a patient safety advisor.</p> <p>To share information across the organization, the interdisciplinary Ambulatory QAPI team, includes leadership from across the organization for their input and buy-in. They report out twice yearly to the Quality & Safety Oversight Committee which allows them to give a summary of the work they have been doing for the year and to ask support of the leadership if needed. Ambulatory QAPI also reports out at the Operations & Quality Meeting quarterly. Lastly, the ambulatory teams that are doing quality initiatives share their work at Ambulatory QAPI and Operations & Quality Meetings so there is bidirectional sharing.</p>
<p>UK Healthcare/Kentucky Children's Hospital</p> <p>Anna Marcinko, anna.marcinko@uky.edu</p> <p>Susan Robbins, susan.robbsins@uky.edu</p> <p>Mark Wolf, mark.wolf@uky.edu</p>	<p>Ambulatory Journey: To start, UK Healthcare/Kentucky Children's Hospital (Kentucky Children's Hospital) identified clinical and non-clinical safety leaders who prompted increased ambulatory safety reporting. They also initiated culture wave work with unique ambulatory training.</p> <p>The General Pediatrics Clinic Director and General and Specialty Clinic Managers were involved. They were identified after discussion with Departmental Clinical and Administrative leaders. Interested QI and Safety champions were interviewed and selected.</p> <p>Kentucky Children's Hospital shares that engagement has been challenging due to faculty and staff fatigue and burnout. Culture wave work has been prioritized for the ambulatory clinics as a whole, while selected teams are engaging in QI work.</p> <p>Regarding health equity, they have been evaluating data integrity of REaL data, the Enterprise DEI leader has engaged system-wide, and they are starting to collect safety data with a DEI lens.</p> <p>Their Ambulatory system structure includes the following:</p> <ul style="list-style-type: none"> ● Ambulatory Manager ● Ambulatory General Pediatric Clinic Director ● Ambulatory Administrative Leader ● Pediatric Medication Safety Officer ● Select Resident QI Champions (TBD) ● Vice Chair Quality, Safety, and Value/Chief Quality Officer <p>Strategic Priorities:</p> <ul style="list-style-type: none"> ● Completion of culture wave training ● Promote depression and suicide screening ● Ambulatory vaccine safety work

	<p>Top Interventions:</p> <ul style="list-style-type: none"> • Culture wave training and focusing on the importance of creating a reporting and learning culture. Encouragement of incident reporting in the clinic space, leading to a 3-4-fold increase of ambulatory incident reports • Medication safety rounds in the ambulatory clinic. Although the program has recently started, there is an overwhelmingly positive response <p>Measurement Strategy: To collect and organize data Kentucky Children’s Hospital uses the RLDatix incident reporting system.</p> <p>Safety stories are shared on the enterprise-wide Daily Briefing for Safety Operations. Ambulatory safety stories are also shared in the Children’s Hospital Monthly Quality and Safety meeting and the departmental Quarterly Quality and Safety Newsletter.</p>
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Safety Disparities

Reference the [SPS Safety Disparities Roadmap Parts 1-3](#) and the corresponding [Change Package](#). Data collection methods for SPS Safety Disparities can be found in the [Race and Ethnicity operational definition](#).

Hospital & Contact Info	Best Practices & Highlights
<p>Children’s Hospital Los Angeles</p> <p>Steven Viramontes, stviramontes@chla.usc.edu</p> <p>Ryanne Salandanan, rsalandanan@chla.usc.edu</p>	<p>Data Collection Method: Scenario #1</p> <p>Harms Stratified by Race and Ethnicity: CLABSI</p> <p>EMR: Cerner & Allscripts</p> <p>Roadmap Part 1 Reflections: This work is organized by a multidisciplinary committee and senior leader sponsorship from DEI and quality. The committee includes nursing and physician clinical leaders, DEI, registration, HIM (medical records), data analytics, and IS, and provides oversight for all demographic data collection including REL, SOGI, Disability, Health Related Social Needs.</p> <p>CHLA notes success with C-suite support for this initiative, and broad interest and engagement from many stakeholders. A challenge is that there are many competing priority changes occurring concomitantly in registration workflow.</p> <p>Methods to get buy-in from the hospital:</p> <ul style="list-style-type: none"> • Connect to actual disparities identified and improvement work successes • Highlight regulatory requirements • Display data around unknown rates on Enterprise Quality and Safety Dashboard <p>Roadmap Part 2 Reflections: CHLA’s processes for obtaining stratified harm data include use of Allscripts, Vigilanz, and Cerner data systems.</p> <ul style="list-style-type: none"> • Numerator: Potential CLABSI events are identified through Vigilanz, which pulls data from Cerner, and confirmed by the IPC Team. The

MRNs are then matched up with REaL data collected in their STAR system. This reconciliation is carried out by the data analytics team.

- Denominator: CVC line days are also collected by the VigiLanz system, which pulls data from Cerner. The MRNs are then matched up with REaL data collected in the STAR system. This reconciliation is carried out by the data analytics team.
- The validation process for data is that the medical record numbers from VigiLanz are matched to REaL data.
- The REaL data is collected by the admitting/registration team and entered into STAR.

Methods to train admitting/registration staff:

- Multiple modalities of training
- All staff complete an online module annually, and also receive in-person hands-on training with role-playing scenarios
- Intranet website is provided with resources: FAQs, job aides, and quick reference cards designed to be taped to workstation monitors.
- Scripting provided for staff to explain why the data helps their hospital provide more equitable care
- Handouts provided to families with explanations and choice options

In the ED, data is collected by registration staff with mobile workstations who collect demographic information in the patient room after the physician has seen the patient. For NICU, transfers, and all inpatients, the admitting registration team reaches out to families after admission to have them come to the admitting window or collect information by phone.

Current PDSA cycles:

- Initial training for all staff, visual aid handouts for families – multiple revisions to trainings and visual aids, addition of in-person case scenario-based training
- FAQs document with scripted responses - gathered feedback from staff and added to this, living document on SharePoint
- Data provided monthly to area leaders with % unknown/decline, also with free-text write-ins, with expectation that areas that entered the errors are responsible for correcting (most write-ins were already existing categories)

One success shared by the hospital is that they have a 1% unknown rate for inpatient expanded options. One challenge for CHLA is that ambulatory has many different workflows for patient entry into the system, some of which do not involve direct contact with families. Additionally, their registration system (AllScripts STAR) does not have capability of having patient-entered data.

Roadmap Part 3 Reflections: CHLA notes success in the improving consistency and accuracy of data using a cleaned source of truth database for

	<p>demographic data. A challenge is that the STAR data is not added to the database until after the patient is discharged and account closed. This leads to delays and changes to previous months' data.</p>
<p>Cincinnati Children's</p> <p>Meghan Fanta, Meghan.Fanta@cchmc.org</p> <p>Anita Pryor, Anita.Pryor@cchmc.org</p> <p>Katie Simon, Katherine.Simon@cchmc.org</p> <p>Maria Geiser, Maria.Geiser@cchmc.org</p>	<p>Data Collection Method: Scenario #4, previously scenario #3.</p> <p>Harms Stratified by Race and Ethnicity: CLABSI, UE-ICU</p> <p>EMR: Epic</p> <p>Roadmap Part 1 Reflections: Work was originally organized into a multidisciplinary improvement team with team leaders meeting regularly with executive sponsors. This project has primarily been under the safety umbrella, though they have established connections with DEI/Human Resources and institutional equity structures. More recently, they've expanded to a broader Safety-Equity Leadership Team and continue to have an improvement team focused on CLABSI and UE disparities work.</p> <p>The hospital continues to work within the evolving structure and development of organizational equity work and priority development – they state this has been more of an ongoing process than a challenge. Cincinnati notes early success in garnering broad support within institutional safety leadership and continually strong organizational support. A challenge and success for them was learning how to share early data with various groups across the institution.</p> <p>Methods to get buy-in from the hospital:</p> <ul style="list-style-type: none"> • Share early data with many groups including key stakeholders to establish the importance • Make connections early on with CLABSI and UE leadership, DEI, registration/access services, and family partners to help guide them in the early phases of this work <p>Roadmap Part 2 Reflections: Processes in use to support REaL data collection:</p> <ul style="list-style-type: none"> • Self-identified REaL data is collected by access services (registration) staff, scheduling staff, and/or by families via self-registration on kiosks, depending on location and point of entry • Access services and scheduling staff are initially trained via an online module on how to collect REaL data. Guidance is available online for staff • The “why” behind data collection is communicated to patients/families by using scripts such as: “By asking about your ethnicity and race we are better able to ensure that all of our patients receive the same level of quality care.” Additionally, the team has presented at their Family Advisory Council (FAC) about the “why” and how they are analyzing the data

	<p>Cincinnati continues to address challenges with ways to collect REaL data at different points of entry. They've identified higher "unknowns" in patients who were transferred into the NICU. The institution uses translation tables across a group of hospitals, but this is being updated and they are engaging teams to work in this area.</p> <p>Recent PDSA cycles include working with access services and IS to "flag" any patients with "unknown" race or ethnicity to increase reliability of collection, and better understanding how patients transferred from other hospitals map into data systems. Presently, there are registration work queues to identify patients who are unknown to resolve this gap more expeditiously.</p> <p>Unknown race and ethnicity data continues to be a challenge that the hospital monitors closely. They meet with IT and access services (registration) on an ongoing basis to identify areas of concern and mitigate as early as possible. The size and complexity of the organization presents challenges in identifying and then fixing issues with data quality, but having partners in various areas engaged in the work has been key.</p> <p>Transitioning their data collection method from scenario #3 to scenario #4 provided an opportunity to monitor for changes in category distribution.</p> <p>Roadmap Part 3 Reflections: The data analyst assigned to the HAC teams matches REaL data to HAC data using SQL to gather data and Excel for analytics. IS maintains a mapped table that is used to assign PHARE race groupings for ease of assignment.</p> <p>When the hospital participated in the 2021 SPS PHARE Cohort, dedicated chart reviewers used a formal validation process with to ensure race and ethnicity categories were mapped correctly to the categories in the SPS operational definition. They do random spot checks to ensure mappings remain accurate. Taking on this challenge early on provided to be important to all future work and has made subsequent data work go more quickly and smoothly for the hospital.</p>
<p>Children's Mercy Kansas City</p> <p>Jessi Johnson, jrjohnson2@cmh.edu</p>	<p>Data Collection Method: <u>Scenario #3</u>, planning to convert to scenario #1 in 2024</p> <p>Harms Stratified by Race and Ethnicity: CLABSI, UE-ICU</p> <p>EMR: Cerner</p> <p>Roadmap Part 1 Reflections: This work is supported by Children's Mercy's Quality & Safety Team and Office of Equity & Diversity. Through this collaboration, there is an established relationship between both teams to provide expertise and guidance from both departments.</p>

One challenge they have experienced in the last year is major changes in leadership and reporting structure for the division that included the quality and safety teams. This had an impact on relationship building with key leaders.

To help gain support for collecting this data, the Office of Equity & Diversity (OED) launched a new DEI strategic plan in 2022 with a new ecosystem under their new Chief Equity & Inclusion Officer. This includes a DEI Executive Council (co-hosted by their CEO) as well as several committees that engage both clinical and non-clinical leaders throughout the organization. Leaders from quality and safety participate in the new council and committees, as well as OED staff attending key meetings related to quality and safety.

Roadmap Part 2 Reflections: Data scientists oversee the current process that took roughly a year to establish and validate with the Infection Prevention and Control Team. A file is generated out of Theradoc with device days that is matched to the race and ethnicity definitions. This automated process now takes a total of 15 minutes monthly.

- This started with a clean process used to collect central line data
- By creating that process, they had a date, device, and medical record numbers (MRN)
- A custom Python code was created to establish the automated process

Since the process has been automated, there is no required training for data collection. However, the Patient Access/front desk/registration representatives have a script for collecting REaL information from families, including reasons the hospital is collecting this information.

- Race and ethnicity data are required fields in their system, and they do their best to collect it upon completion of registration or admission
- If they are not completed upon admission, they will follow up with the family to collect later once care is established, prior to discharge
- Additionally, self-identification is the process they follow, discouraging any visual observation by staff for patient identity

Children's Mercy completed approximately 12 PDSAs to establish the process in making sure they had the infection control data cleanly captured by day, patient, and unit.

This hospital identified that establishing the process was originally very time-consuming and required more resources than were available at the time due to staffing. In the context of this challenge, a related success is the formation and execution of a REaL Data Task Force to evaluate the current system and provide recommendations for improvements. Those recommendations will be provided to the DEI Executive Council for implementation next year. These improvements will allow them to collect data that is more accurate, addressing concerns or flaws in the process one by one.

	<p>Roadmap Part 3 Reflections: Data is matched by HAC data and once the automated data process is complete, it is transferred to a Database Coordinator in the Quality & Safety Team for review. Data is validated in a similar process where they have a report that they marry by MRN to the devices, which is the same thing with the infections.</p> <p>Children’s Mercy knows there are existing issues with the collection of race and ethnicity data that they hope to improve upon next year. Current race/ethnicity options align with the federal standard but are not sufficient to capture a patient’s identity as fully or accurately as they would like.</p> <p>The team is challenged due to the fact that their current internal data doesn’t have significant variance by race/ethnicity to guide next steps. Many more months of data are required to complete a large enough dataset that may identify gaps or opportunities to improve.</p>
<p>MUSC Shawn Jenkins Children's Hospital</p> <p>Hadassah Little, littleh@musc.edu</p>	<p>Data Collection Method: Scenario #4</p> <p>Harms Stratified by Race and Ethnicity: CLABSI, UE-ICU</p> <p>EMR: Epic</p> <p>Roadmap Part 1 Reflections: MUSC’s work is organized primarily through the Quality and Safety Team who oversees data collection, data analysis, and action plans.</p> <p>For MUSC, their biggest success is data capture; they have both process and outcome data for CLABSI and UE available. They believe their biggest challenges are yet to come as they are still early on in their journey and have been focusing on refining the data collection process. They look forward to analyzing the data and implementing action plans in response.</p> <p>To get leadership support, they ask for their help in voicing the need for this data collection. It is still not decided when they can start action planning as a result of data analysis.</p> <p>Roadmap Part 2 Reflections: Data is collected by the registration team who goes through an internal training process. These staff communicate the reasons for data collection verbally with patients/families, and will also follow up when necessary at the bedside after a patient is settled in.</p> <p>MUSC hopes to improve but states that their registration team does an excellent job of collecting this data. They have recently discovered they could improve on selection of more than one race category when applicable.</p> <p>Roadmap Part 3 Reflections: The Quality & Safety Team is part of the process of matching this data with HAC data. Tableau is used to capture line and vent days. Verge is used to collect outcome data and race/ethnicity associated with</p>

	<p>K-card data. Tableau dashboards underwent extensive manual validation during the build phase. However, validation is continuous, and their team may have recently discovered an error impacting their “unknown” and other categories that is being addressed immediately.</p> <p>As they continue to refine data, MUSC is looking forward to beginning work to reduce the number of patients categorized as “unknown,” as well as improving the number of patients appropriately categorized with multiple race categories when applicable.</p>
<p>Seattle Children's</p> <p>Kristina Toncray, Kristina.Toncray@seattlechildrens.org</p> <p>Shanda Johnson, Shanda.Johnson@seattlechildrens.org</p>	<p>Data Collection Method: Scenario #4</p> <p>Harms Stratified by Race and Ethnicity: CLABSI, UE-ICU</p> <p>EMR: Epic</p> <p>Roadmap Part 1 Reflections: Seattle Children’s commitment as an organization is to embed equity focus in all they do, inclusive of quality core measures and safety work. They do not have a singular team dedicated to safety disparities improvement; however, they do embed this focus in all quality workstreams. Metrics and associated improvements are followed by the HAC Oversight Committee and other quality governance (HAC Oversight, QISC Committee, HEAR Council).</p> <p>Successes and challenges faced include:</p> <ul style="list-style-type: none"> • Shared understanding of scope, stakeholders, and objectives for safety disparities improvement work. Some are well-scoped, but newer workstreams have opportunity • Though they did not complete the safety disparities project plan utilizing the SPS roadmap, as their hospital’s planning was completed independently, there is alignment in concept • The hospital has not specifically reviewed the SPS roadmap with HAC Oversight, HEDI or HEAR council, though they do have organizational leadership that was part of the development of the SPS safety disparities effort • Seattle Children’s has established processes for stratifying HAC data and most quality core measures and by REaL variables <p>As part of the Health Equity and Anti-Racism (HEAR) Plan, the organization was directed to do the following for FY23:</p> <ul style="list-style-type: none"> • Decrease overall CLABSI rates and eliminate CLABSI disparities. Meet two of the three following components: Decrease overall FY23 CLABSI rate to 1.17 per 1000 line days. Current results: 1.31 • Eliminate disparity of CLABSI rates for Black and African American patients. Current results: 1.29 • Eliminate disparity of CLABSI rates for LOE (language other than English) patients. Current results: 0.80

- Since this division goal has been set by executive leadership, the expectation is that all teams work in alignment towards this goal. The HEAR Plan is one of Seattle Children's "north stars" of quality improvement and an inherent part of their patient safety work. In addition, the Center for Diversity and Health Equity co-owns the CLABSI metrics for Black or African American and LOE patients and are key partners in driving this improvement work forward

Roadmap Part 2 Reflections: For REaL data collection, UE numerators are tracked by the Respiratory Therapists (RT) Quality & Safety Program using RLDatix (eFeedback) reports, Reporting Workbench (RW) reports, and sometimes Code Blue Review. UE denominators are aggregated from billed ventilator days which is exclusive to RT workflow. REaL data are derived from and associated with UE numerators.

The RT Quality & Safety Program is a two-person team including the program manager that has standard onboarding/training. The RT staff are trained to bill for ventilator days during standard onboarding/training.

Seattle Children's does not communicate why data is collected with patients/families as RTs are not involved in REaL data collection at points of entry.

A success for this hospital is that the data selection process has been well established at Seattle Children's, however they have not used the SPS safety disparities guidance document to validate.

Roadmap Part 3 Reflections: Seattle Children's UE HAC Leader in the RT Quality & Safety Program and CLABSI Infection Prevention completes this part of the process.

Data systems used include:

- CLABSI – EPIC, Enterprise Data Warehouse (EDW), Tableau
- UE – RLDatix, EPIC, MS Access, Enterprise Data Warehouse (EDW), Tableau

The data validation process is:

- UE numerators are validated with clinical documentation in EPIC.
- Billed ventilator days are an established process at Seattle Children's; last validated during transition from Cerner to EPIC in FY 2021
- CLABSI numerators are adjudicated by Infection Prevention according to NHSN criteria
- Central line days are determined by Epic LDA documentation

Seattle Children's states that not having a designated safety disparities team is a challenge, however, they have established processes for stratifying HAC data and most quality core measures by REaL variables. These metrics and

associated improvements are followed by HAC Oversight Committee and other quality governance committees.

Executive Highlight

SPS strongly believes that CEO engagement is essential to promoting a culture of safety. We wanted to showcase our outgoing and incoming SPS Board Chairs that embody our mission of eliminating serious harm across all children's hospitals. In addition, we asked their Quality Leader to explain how CEO engagement is essential to promoting a culture of safety within their organization.

SPS asked Marcy Doderer, current SPS Board Chair and Arkansas Children's Hospital (Arkansas Children's) President and CEO, to share her perspective on promoting a culture of safety. Below is her response:

"The CEO's support of a strong safety culture is imperative for such a culture to thrive. My support shows up in my words, actions, and behaviors. Arkansas Children's has four core values: Safety – Teamwork – Compassion – Excellence. They are always written or spoken in that order. Having 'safety' as our leading core value provides an unwavering commitment to a culture of safety – regardless of how other strategic or organizational priorities might shift. I make every effort to attend New Employee Orientation where I spend time discussing our mission, vision, and values and my expectations for what behaviors must be exhibited to meet all of those foundational tenets. During orientation, new team members verbally commit to an unyielding commitment to safety of self and patients and families. As CEO, it's important for me to have a strong cadence to the work that reinforces our culture and our journey towards zero harm:

- *Daily – Participate in System Safety Brief*
- *Weekly – Round in one or two departments, ensuring employee and patient safety are part of the conversations with staff*
- *Bi-Weekly – Kick-off Employee Orientation to set the tone*
- *Monthly – Attend as a voting member of the Board Quality and Safety Committees for both hospitals; review/discuss quality score cards with CEO Cabinet; round with ACH Board Chair*
- *Quarterly – Lead the CHSPS meeting with HAC Team Leads to review data, celebrate successes, and discuss barriers needing senior leader attention*
- *Three Times/Year – Host Employee Forums (town hall meetings) that always include at least one safety discussion point*
- *Annually – Ensure at least one safety related incentive compensation goal for all leaders (department director to CEO). (Current year is a system-wide Preventable Harm Index goal weighted at 25% of total incentive comp)*

All of this work is connected by a mindset of being present and approachable, ensuring transparency of data and results, and being supportive when our systems fail us. We have much work to do but I am really pleased with the progress we have made. Participating in CHSPS helps keep us centered and allows us to advance the workday after day."

Marcy Doderer, FACHE
President & CEO at Arkansas Children's Hospital
DodererML@archildrens.org

SPS asked Stephanie Evans, Quality Leader at Arkansas Children's, to share how the President and CEO Marcy Doderer supports the culture of safety. Below is their response:

“During her tenure as CEO at Arkansas Children’s, Marcy Doderer has demonstrated an unwavering commitment and support to safety that has resulted in a fundamental culture transformation over the last 10 years. She set the stage for this transformation early on by re-defining our organizational core values, putting safety as our number one guiding principle. Her message has remained clear and consistent over time: ‘We may not be perfect, but we will be excellent, and we will be relentless in our pursuit of safety.’ This consistent message has trickled down to every leader and every frontline staff member in our system so that the expectations are clear. She has also been very intentional about elevating employee safety to the same level as patient safety. At Arkansas Children’s, we have removed the adjective from safety because of Marcy’s leadership.

Marcy is a very visible and approachable leader. She is present during our daily organizational safety briefings; she regularly rounds on our frontline teams to understand the challenges they face and the barriers that she may be able to help remove. She promotes data transparency, and she understands and is able speak to our organizational safety data. Each quarter, Marcy chairs our internal SPS meeting, which provides a venue for all HAC leaders, champions, and departmental leaders to discuss our performance with HACs. Having her leading presence at this meeting sends a very clear message that this work is a priority, and once again, it provides our teams with access to the CEO to help overcome barriers they may be facing. She also chairs our RCA Oversight Committee, which meets monthly. In this venue, we discuss process and outcome metrics, as well as learnings/action plans from analyses that have occurred, and any challenges that we may be encountering in executing those actions. Marcy has supported and advocated for forming working partnerships with our patients and families, so that our families help to inform our work, and are involved at governance levels. Marcy asks the difficult questions, she challenges us to be better than the day before, all the while celebrating the successes and wins that we have accomplished along the way.”

Stephanie Evans
Quality Leader at Arkansas Children’s Hospital
EvansSL@archildrens.org

SPS asked Rick Merrill, incoming SPS Board Chair and Cook Children’s Health Care System President and CEO, to share his perspective on promoting a culture of safety, below is his response:

“A preeminent priority for any health care organization must be safety and quality. After all, patients’ lives and well-being hang in the balance. With Zero Harm as our goal at Cook Children’s, safety and quality are more than metrics we set for ourselves, but a value we all share. It guides both our strategic planning and our organizational culture.

Instilling this value into our culture starts at the top and on day one. A commitment I made early in my tenure at Cook Children’s was to speak at every new hire employee orientation so that our people know they are valued and supported at the highest levels of the organization. I spend a great amount of time talking about Zero Harm. At the end of my presentation, I make a promise to ensure that every employee has the tools, the time and the resources to do their job so that their focus can be on delivering safe and quality care.

Thankfully, I’m not alone in that promise. Our board of directors is briefed on safety data at every meeting, and prioritizes safety in its decisions and actions, showing the entire organization the importance of making safety a

fundamental value.

In addition to equipping everyone to deliver safe and quality care through ongoing education and training, we engage every level of the organization in the discussion of and responsibility for safety, quality and equity. Leaders and staff from across the organization participate in our daily safety briefing. We also conduct weekly safety rounds thanks to a new initiative we call “No Meetings Wednesdays.” Each Wednesday we clear our calendars to allow time for senior level leadership and directors to round with frontline staff and hear from them about their needs and challenges concerning workplace and patient safety, and identify resources needed to overcome them. This dedicated time for open, face-to-face communication and collaboration has quickly become a favorite of mine.

Our event reporting system also allows us to maintain an open and transparent line of communication regarding safety concerns, incidents and near misses without fear of retribution. A number of safety and quality committees play a critical role in shaping our safety culture by discussing safety issues, making recommendations for improvements, and fostering a sense of shared responsibility. Best of all, many of these committees include input and involvement from those most impacted by their work—the patients and families we serve.

One of the things we’ve learned from all of these activities is that one size does not fit all when it comes to safety and quality initiatives. So we allow every department to identify and address specific safety and quality concerns tailored to their unique roles and the needs of the patients they serve. This puts the power for these decisions into the hands of those delivering the care. We recognize and reward the teams and individuals that excel in safety practices and achievements with the goal of making safety and quality more than a mandate, but the motivation for our standard of care.

I’ll be the first to admit, it’s a lot to juggle. One of the biggest challenges facing CEOs in today’s health care environment is prioritizing the organization’s many competing initiatives. As CEOs, we all have much to accomplish, and our teams’ plates are just as full. Without discipline, it is easy to get sidetracked. This is why it’s so important to set clear and manageable goals for ourselves, our teams and our organizations. We need these checks and balances to ensure that we’re majoring on the majors, and not on the minors. Being part of the SPS collaborative has been invaluable in providing structure, support and focus around our top hospital acquired conditions (HAC) and safety goals.”

Rick W. Merrill

President & CEO at Cook Children’s Health Care System

Rick.Merrill@cookchildrens.org

SPS asked Dr. Joann Sanders, Quality Leader at Cook Children’s, to share how the President and CEO Rick Merrill supports the culture of safety. Below is their response:

“The following list are specific examples of how our CEO, Mr. Merrill, supports the culture or safety within our institution:

- 1. He attends, alongside new board members, SPS Board training annually*
- 2. He leads by example by serving as the 2024 SPS Board Chair*
- 3. When SPS launched the employee safety initiatives (Patient behavior events, Slips/Trips/Falls, and Overexertion) he approved the creation of a new occupational health position with the primary role of working with quality and safety staff, to lead and manage this work*

4. *He instituted “no meeting Wednesdays” to allow time for senior level leadership and directors to round on front line staff*
5. *He is serving as our executive leader in the new pioneer cohort for employee injuries*
6. *He led the creation of videos, in the spirit of all teach all learn, so that other organization can see what we are working on to prevent harm*
7. *Quality and safety goals are 25% of the strategic goals for our organization*
8. *He has served as an executive champion for serious safety events*
9. *He has funded a \$50,000 program to incentivize hospital units to go above and beyond to prevent hospital acquired conditions*
10. *Quality reports proceed financial reports in board meetings*
11. *He speaks at every new employee orientation, twice monthly, and includes quality and safety topics*

His support of our Zero Harm program is one of the primary reasons for our success.”

Joann Sanders

Quality Leader at Cook Children’s Medical Center

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Past SPS SHINE Hospitals by Region

(from the last two years)

The past SPS SHINE Reports can be found on SharePoint by [clicking here](#).

Atlantic Coast

Hospital	HAC/Culture	SHINE Date
UPMC Children's Hospital Pittsburgh	UE	2021
WVU Medicine Children's	ESS	2021
Bristol-Myers Squibb Children's Hospital	Falls	2022
Penn State Hershey Children's Hospital	Culture	2022

California

Hospital	HAC/Culture	SHINE Date
Valley Children's Hospital	CLABSI (21) (22)	2021, 2022
Children's Hospital Los Angeles	CLABSI (21), UE (22)	2021, 2022
UCLA Mattel Children's Hospital	CLABSI	2022

Canada

Hospital	HAC/Culture	SHINE Date
McMaster Children's Hospital Hamilton Health Sciences	CLABSI Hem-Onc	2022

Florida

Hospital	HAC/Culture	SHINE Date
Advent Health for Children	UE	2021
Wolfson Children's Hospital	CAUTI	2021
Johns Hopkins All Children's Hospital	ADE	2022
Nicklaus Children's Hospital	CLABSI	2022
St. Joseph's Children's Hospital of Tampa	SSI	2022
Arnold Palmer Hospital for Children	UE	2022

Minnesota

Hospital	HAC/Culture	SHINE Date
N/A	N/A	N/A

Midwest

Hospital	HAC/Culture	SHINE Date
Children's Mercy Kansas City	Falls	2021
Riley Hospital for Children at Indiana University Health	Culture	2021
Helen DeVos Children's Hospital	Culture	2021
Arkansas Children's Hospital	UE (21)	2021
CS Mott Children's Hospital	CLABSI	2021
SSM Health Cardinal Glennon Children's Hospital	ADE	2022
Children's Hospital of Wisconsin	CLABSI Hem-Onc	2022
Advocate Children's Hospital	Culture	2022

New England

Hospital	HAC/Culture	SHINE Date
Boston Children's Hospital	UE	2022
Yale New Haven Children's Hospital	Culture	2022

New York

Hospital	HAC/Culture	SHINE Date
Hassenfeld Children's Hospital at NYU Langone	PI (21), SSI (22)	2021, 2022
Cohen Children's Medical Center of NY	CAUTI	2022
Kravis Children's Hospital at Mount Sinai	UE	2022

Ohio

Hospital	HAC/Culture	SHINE Date
Cleveland Clinic Children's	NON-CVC VTE (21), CLABSI (22)	2021, 2022
Akron Children's Hospital	SSI (21)	2021
Nationwide Children's Hospital	Falls (21), ESS (22)	2021, 2022
UH/Rainbow Babies and Children's Hospital	CAUTI	2021
Dayton Children's Hospital	ADE	2021
Promedica Russell J. Ebeid Children's Hospital	ESS	2022
Cincinnati Children's	UE	2022

South

Hospital	HAC/Culture	SHINE Date
Children's Hospital New Orleans	ESS (21), CAUTI (22)	2021, 2022
Ochsner Hospital for Children	ESS	2022
Arkansas Children's Hospital	Falls	2022
UK Healthcare/Kentucky Children's Hospital	PI	2022

Tennessee

Hospital	HAC/Culture	SHINE Date
Niswonger Children's Hospital	PI	2021
Monroe Carell Jr. Children's Hospital's at Vanderbilt	ESS	2021
Le Bonheur Children's Hospital	ADE	2021

Texas

Hospital	HAC/Culture	SHINE Date
Texas Children's Hospital	SSI (21), PI (22)	2021, 2022
Texas Scottish Rite Children's Hospital	NON-CVC VTE	2021
Driscoll Children's Hospital	ESS	2022

West

Hospital	HAC/Culture	SHINE Date
Phoenix Children's Hospital	UE (21), CLABSI Hem-Onc (22)	2021, 2022
Mary Bridge Children's Hospital & Health Network	PI	2021
Children's Hospital Colorado	Culture (21)	2021
Kapi'olani Medical Center for Women and Children	CLABSI	2021
Doernbecher Children's Hospital	CLABSI	2022