SADDLE UP TO SAFETY
EVERYBODY ROPES EVERYBODY RIDES

McLane Children's Medical Center

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1. Background

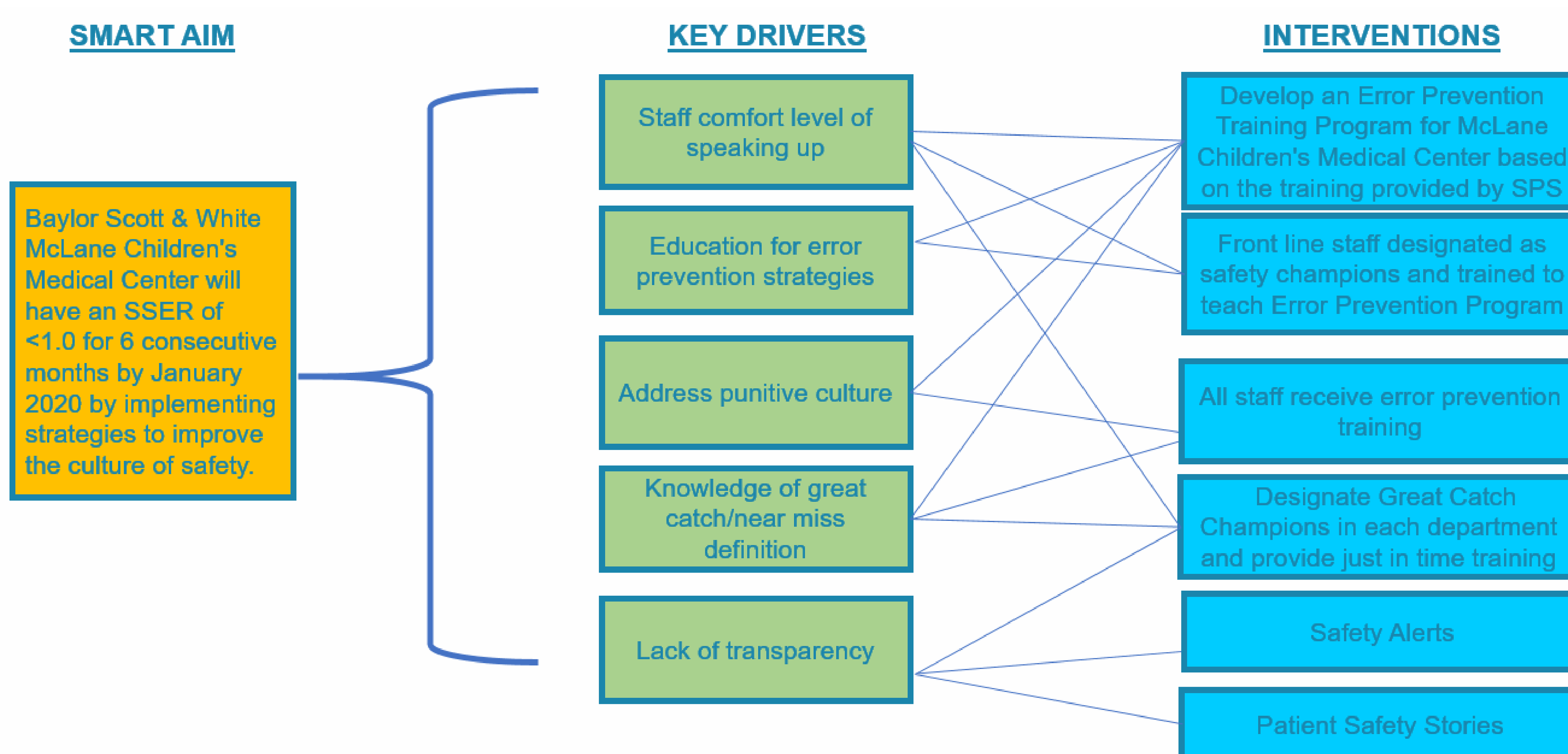
In June 2016, McLane Children's Medical Center (MCMC) joined Children's Hospitals Solution for Patient Safety (SPS) to develop evidence-based practice around reducing hospital acquired condition and Serious Safety Events (SSEs) utilizing The Patient Safety Measurement System developed by Healthcare Performance Improvement, LLC. A SSE is an event that causes moderate to severe patient harm or death. SPS has a goal of a monthly Serious Safety Event Rate (SSER) <1.0. MCMC was not meeting this goal for 10 consecutive months. Leadership wanted staff to have the tools and bundles to decrease the hospital's monthly SSER.

2. Problem Statement

Between June 2016 and May 2017, the MCMC SSER >1.0 for 10 consecutive months.

The staff did not have the tools or knowledge in cultural safety to prevent serious harm to patients. Leadership at MCMC wanted staff to have tools and bundles to decrease the number of SSEs and prevent harm to patients. The SPS Benchmark is a monthly SSER <1.0.

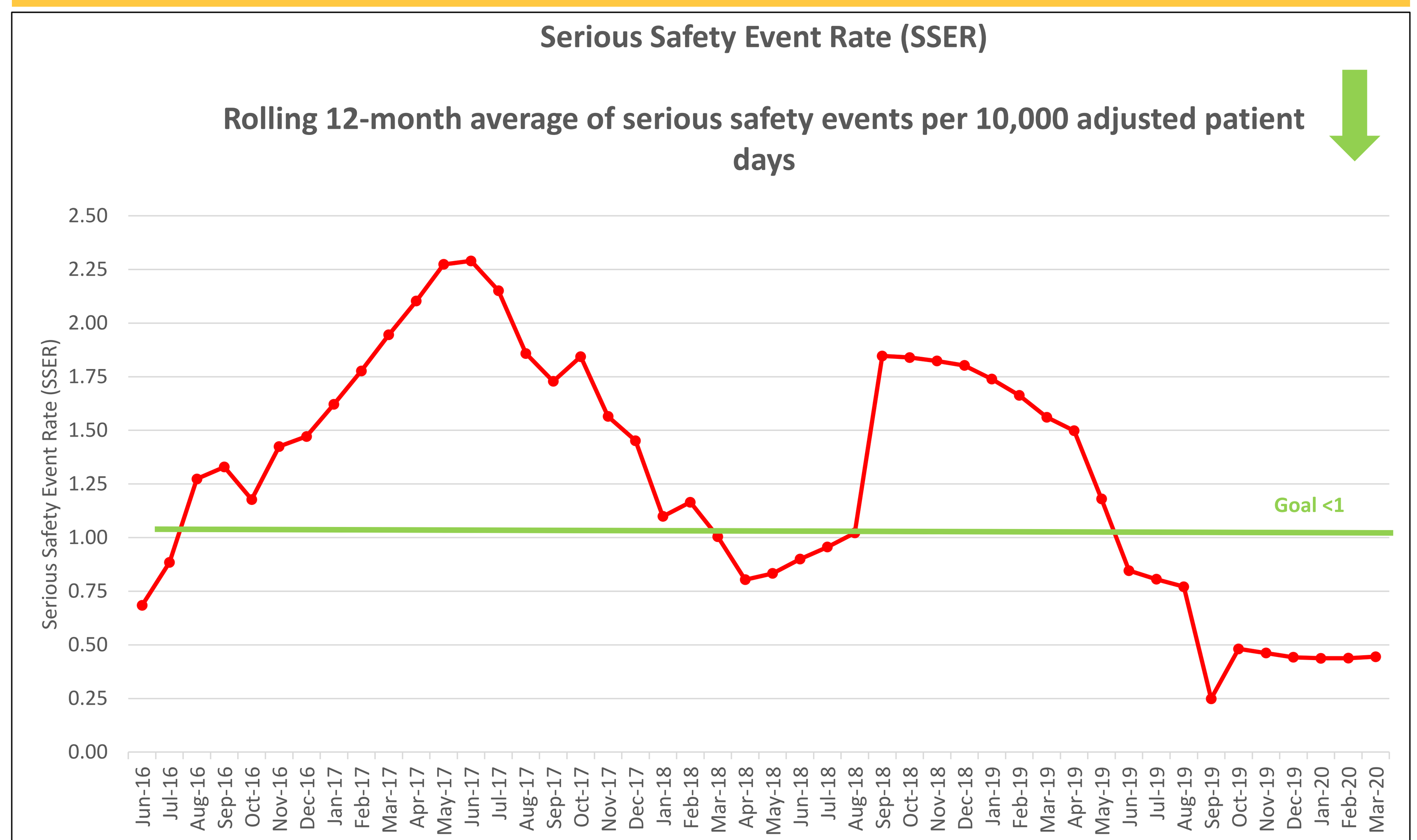
3. Understand The Problem



4. Implemented Change

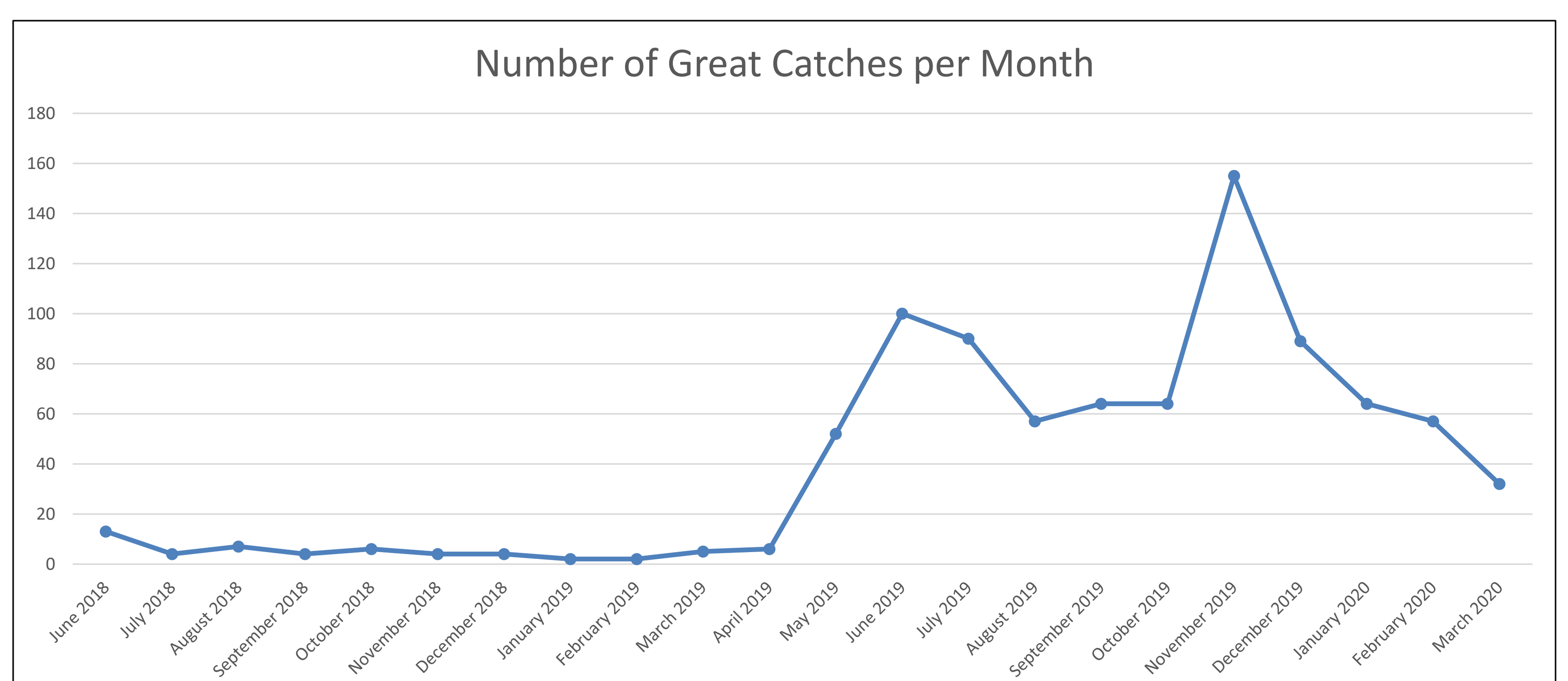
1) During May 2018, individuals in each department at MCMC completed SPS McLane Children's Error Prevention "train the trainer" to become department Safety Champions. This allowed front-line staff to take ownership of spreading the culture of safety. The SSER was below the SPS goal of 1.0, however was trending up. This was the beginning of staff at MCMC being in the "Awareness" phase.
2) Department Safety Champions began teaching all staff at MCMC error prevention training including implementation of Behavioral Expectation Tools. This caused an increase in event reporting ending the "Awareness" phase and entering "Skill Acquisition".
3) In August 2018 the SSER went above goal. A need was identified for better education on great catch reporting. A Great Catch Program with Champions was created. The Great Catch Program decreased the SSER. Staff transitioned from "Skill Acquisition" to Habit Formation".

5. Calculate & Demonstrate The Success



June 2016 – MCMC joins SPS; begins collecting SSER data with reporting definitions aligned to SPS
June 2017 –CMO/CNO made a hospital FY18 goal to address issue of increased SSER; Executive Leadership agreed to send select staff to SPS training
July 2017 – Feb 2018 – Increased awareness related to SSEs through Patient Safety Stories shared in Leadership and Shared Governance Quality & Patient Safety Councils; This increased awareness was the primary reason for SSER improvement between July 2017 – April 2018
March 2018 – Select staff attended SPS training and began developing a SPS Train the Trainer Course tailored for McLane Children's Hospital

Date	Days between SSE's
FY17	26.1
FY18	121.7
FY19	121.7
FY20- YTD	137.5



6. Lessons Learned

- Mandatory attendance for Pediatric Providers to attend training.
- More celebration of milestones and involvement with great catch champions.
- Need for leadership method training to assist staff with behavioral tools.
- Individuals working outside of MCMC that are shared services are unaware of ideas, strategies and culture established for error prevention.

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