Elective: Pediatric quality & patient safety

Faculty mentors: Drs. Elizabeth Mack & Caughman Taylor

Duration: 2 weeks

Available to: PGY-2, -3, -4

Goals:

-Develop an understanding of and advocacy skills in QI for today`s practicing pediatrician & subspecialist

-Provide a hands-on experience in QI, systems-based practice, and exposure to tools to apply in practice

Objectives:

-Complete readings and projects on quality patient care and optimal patient care systems

-Work in interprofessional teams to enhance patient safety and improve patient care quality

-Participate in identifying system errors and implementing potential systems solutions

Summary:

Residents will get exposure to organizational approaches to patient safety and quality improvement, and be an active participant and contributor to developing and implementing solutions to systems-based problems. Residents will participate in key safety/quality meetings at the organizational level. The curriculum is flexible and can be tailored to suit residents' interests, and residents are encouraged to contact the elective director 1-2 months in advance in order to customize the rotation to meet their interests. Residents will implement one system change based on an event or near-miss and begin a PDSA cycle to assess change.

Specific expectations:

1. **Hospital committee experience** (as below & others prn)

Meeting	Time	Place	Notes
CHOC	1st Mon of month 0730	Derrick room	
PHQC	1st Mon qomonth 1730	Corporate bd rm	Even months
Trauma outcomes	1st Wed of month 1600	3 Med. Park, suite 200	
VAP	2nd & 4th Wed 1300	Catawba classrm, HH	Twice monthly
CH Leadership team	Every Wed 1400	CH admin suite (Shirley)	weekly
P&T	2nd Thurs of month1700	1501 Sumter- mtg rm2	
RRT/code	3rd Mon of month 1400	Edisto classrm, HH	
CAUTI	3rd Wed of month 0900	HH atrium classrm	
CLABSI	3rd Wed of month 1000	HH atrium classrm	
NACHRI CLABSI	3rd Wed of month 1500	Derrick or Rainey	
Safety Rounds	4th Wed of month 1530	CH admin suite (Shirley)	
Pt care & safety	3rd Wed of month 1700	3 Med. Park, suite 200	
Occurrence report rev	As scheduled, qomonth	14mp ste 400	Every other month
CH surg committee	As scheduled, quarterly	Derrick	
Peds sedation/anes	As scheduled, quarterly	Peds sedation	
Code assessments	As scheduled, qmonth	Sim center	

2. **Didactic & self-directed learning**: read & discuss articles below

a) Fan E, et al. How to use an article about quality improvement. *JAMA* 2010;304:2279-2287

b) Miller M, et al. Decreasing PICU Catheter-associated bloodstream infections: NACHRI's quality transformation efforts. *Pediatrics* 2010 ;125:206-213

c) Perla RJ, et al. The run chart: a simple analytical tool for learning from variation in healthcare processes. *BMJ Qual Saf* 2011;20: 46-51

d) Medical errors module on www.mysccm.org (see attached module instructions)

e) Classen DC, et al. Global trigger tool shows that adverse events in hospitals may be 10 times greater than previously measured. *Health Affairs* 2011;30:581-589.

f) Mack EM, et al. Clinical decision support systems in the pediatric intensive care unit. *Pediatric critical care medicine* 2009;10:23-28.

g) Napper C, et al. Pediatrics and patient safety. *J Pediatr* 2003;142:359-60.

h) Volpp KGM, et al. Residents' suggestions for reducing errors in teaching hospitals. *NEJM* 2003;348:851-855.

i) Fernandez CV, et al. Strategies for the prevention of medical error in pediatrics. *J Pediatr* 2003;143:155-62.

j) Stucky ER, et al. Prevention of medication errors in the pediatric inpatient setting. *Pediatrics* 2003;112:431-6.

3. **Incident investigation**

-Review last month's occurrence report summary and prepare to present to residents

-Chart review of most recent mortality and presentation at CH Leadership team

-Participate in SWAT (if infection or harm occurs in CH)

-Prepare safety rounds report and present to CH Leadership team & residents

4. **Individual project**

- Propose, modify, and implement system change based on occurrence report after review with CH Leadership team

Other suggested reading: *Checklist Manifesto, To err is human, Crossing the Quality Chasm, Complications*

Attachments: Articles, Module instructions