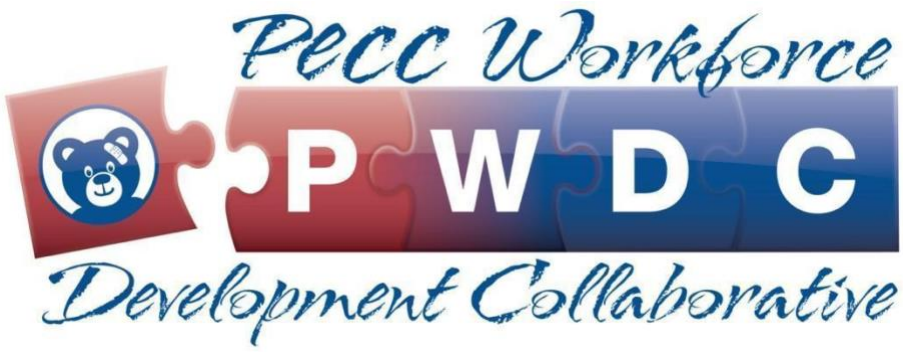


PATIENT SAFETY & FAMILY-CENTERED CARE

Focus Area #2

TABLE OF CONTENTS

Purpose Statement **2**

Background **2**

Testimonials **2**

Flow Diagram **4**

Environmental Scan Worksheet **5**

Key Drivers & Change Strategies **9**

1. 9*2.*

9*3.*

10*4.*

11**Resources**

11

Tools *11*

Templates *12*

Articles *13*

PURPOSE STATEMENT

Establish policies and practices that reflect the unique needs of pediatric patients to promote patient safety. Recognize that family-centered care is integral to ensuring that patient and family perspectives, choices, knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

BACKGROUND

According to the Institute for Patient- and Family-Centered Care, Patient- and family-centered care is an approach to the planning, delivery, and evaluation of healthcare.[1] Family-centered care should be integrated into all healthcare experiences to support pediatric patients and their families' physical, psychosocial, emotional, and developmental well-being during a potentially stressful and/or invasive health care event. As an advocate for children, the PECC can:

- Support a culture of safety that encompasses every interaction with a pediatric patient and their family.
- Encourage information-sharing to promote participation in medical care decision-making and seek to help family members retain a sense of control during emergency medical care.
- Provide the opportunity for family presence during medical transport or invasive procedures.

Patient safety encompasses every healthcare worker's interaction with a patient or family, from collecting history, treating a patient, to handoff. A focus on patient safety can help identify processes and opportunities to prevent errors in any of these interactions. By recognizing the value of a family's knowledge about a patient's condition, the PECC should engage patients and families.

Current research shows biases can lead to different treatments based on race, age (e.g., young mother), gender, etc. and can result in poorer outcomes. Cognitive bias is defined as a bias that causes misinterpretation of information. This can ultimately lead to medical errors. The first step to prevention of such errors is to reflect and identify the biases we each have developed as a result of our environment or past experiences. Patients and families may also present with their own biases based on past treatment. The PECC can play a major role in developing a process to assess for bias when pediatric safety events occur and continually looking for opportunities to minimize biases.

TESTIMONIALS

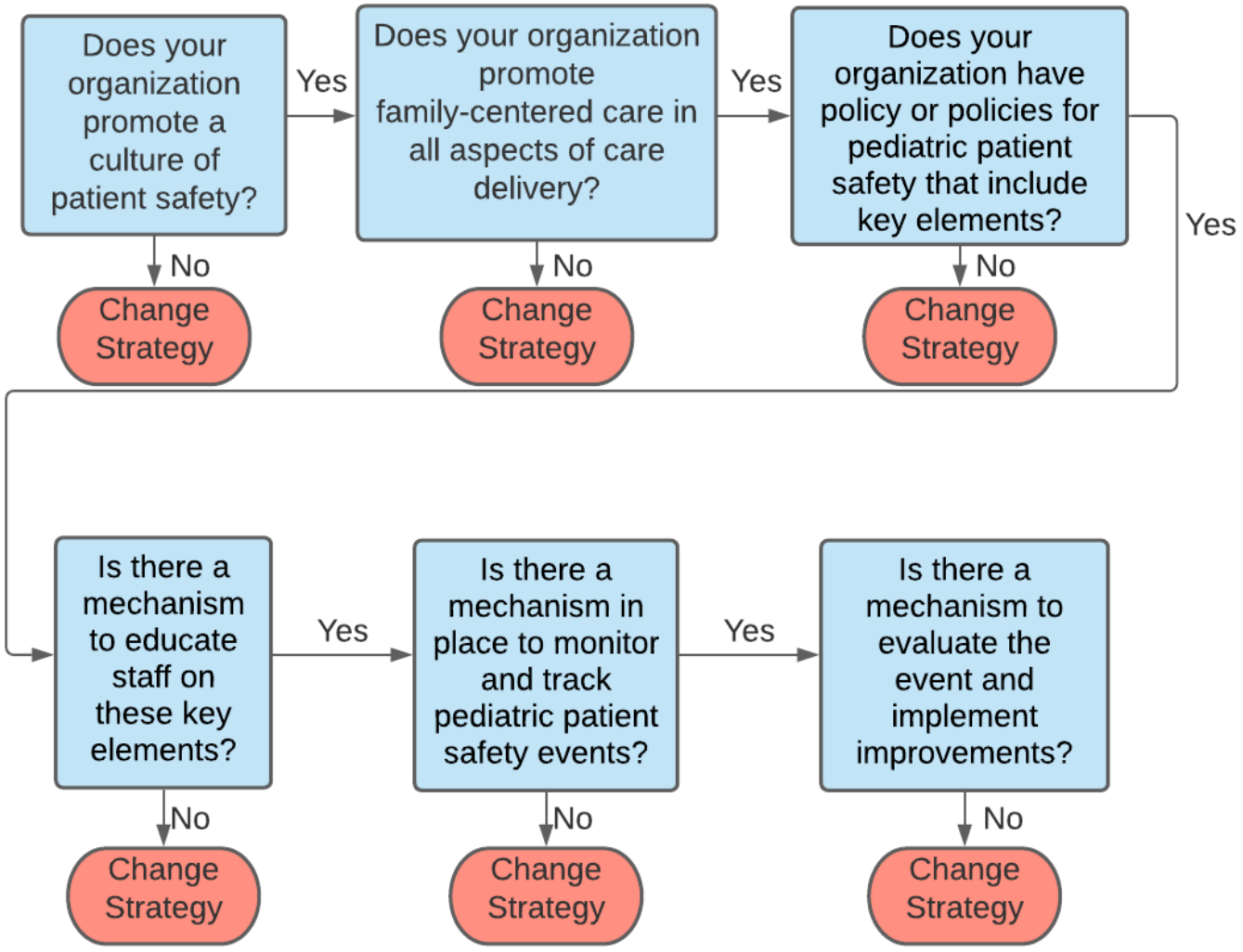
> *"We also do a lot of community outreach, safety town injury prevention programs, anything that we can to help make sure the kids in our community are served." (EMS Agency PECC)*

[1] Patient- and Family- Centered Care Defined. Ipfcc.org. https://ipfcc.org/bestpractices/sustainable-partnerships/background/pfcc-defined.html. Accessed February 1, 2021.

> *"...In the process of treating a pediatric, we encourage our providers to involve the family as much as they can in the process or the treatment in that sense kind of thing, trying to tell the providers to allow the family if possible to be involved in the treatment and care of the child." (EMS Agency PECC)*

FLOW DIAGRAM

This flow diagram is designed to help one think about how to break down this focus area into small steps. The questions in this flow diagram align with the environmental scan worksheet in the next section.



ENVIRONMENTAL SCAN WORKSHEET

Focus Area 2: Patient Safety & Family-Centered Care

Environmental Scan Worksheet

Instructions

The purpose of these questions is to help you explore the current state of the focus area at your EMS agency, ED, or hospital and identify areas for improvement. To be eligible for CE credit, you must answer the Yes/No and strengths/barriers questions in REDCap. The "Key Considerations / Considerations", "Best / Suggested Practices" and "Possible Change Strategies" sections are not required but are designed to help you delve deeper into the question, capture best practices shared during learning sessions, and help strategize on how to improve in this area. Please remember that there is an individual link to each of these forms. Please email Meredith Rodriguez at collaboratives@emscimprovement.center for assistance.

1) Does your organization promote a culture of pediatric patient safety?		☐ Yes ☐ No
Key Elements / Considerations	Best / Suggested Practices	Possible Change Strategies
Culture can be defined as "the way we do things around here". *How is a culture of safety promoted?* *What is the strongest factor driving the culture of the organization (e.g., reimbursement rates)?* *If no, why is a culture of safety not a priority for the organization?*	*What are groups doing around the country that you think could work well for your agency or ED/hospital?* *How do they promote a culture of patient safety?*	*What could be done to improve here?* *Relevant Key Driver(s): 1-Culture*
2) Does your organization promote family-centered care in all aspects of care delivery?		☐ Yes ☐ No
Key Elements / Considerations	Best / Suggested Practices	Possible Change Strategies

What works well to promote engagement of families? *Are there specific care processes that could serve as a model of family engagement?* *What specific aspects of care delivery are lacking family engagement? Are there reasons for this?*	*How are others engaging families in care delivery?* *Which of these strategies could easily be incorporated into your organization?*	*What could be done to improve here?* *Relevant Key Driver(s): 1-Culture*

3) Does your organization have policy or policies for pediatric patient safety that include key elements?	☐ Yes ☐ No

Key Elements / Considerations	Best / Suggested Practices	Possible Change Strategies
Key elements of pediatric patient safety include: ● *medication administration* ● *all children or weighed (or estimated) and documented in kilograms only, with the exception of children who require emergency stabilization.* ● *collection of a full set of vital signs* ● *safe medication (including blood products) prescribing, delivery, and disposal.* ● *safe transport of pediatric patients*	*What are others doing around the country to promote patient safety and family-centered care?*	*What could be done to improve here?* *Relevant Key Driver(s): 3-Practices & Procedures, 4-Processes & Policies*

4) Is there a mechanism to educate staff on these key elements of pediatric patient safety and family-centered care?	☐ Yes ☐ No

Key Elements / Considerations	Best / Suggested Practices	Possible Change Strategies
What mechanisms are employed? *Is the training high-quality, enabling immediate implementation of these practices?* *How often are staff trained on these elements?* *If no, how are staff made aware of practices or policies that enhance*	*What strategies do PECCs around the country employ to train staff on key elements of pediatric patient safety?*	*What could be done to improve here?* *Relevant Key Driver(s): 2- Education & Awareness*

patient safety and family-centered care?		

5) Is there a mechanism in place to monitor and track pediatric patient safety events?	☐ Yes ☐ No

Key Elements / Considerations	Best / Suggested Practices	Possible Change Strategies
How are safety events tracked? *Is there a mechanism to specifically include/extract pediatric events?* *What type of safety event occurs most often with your pediatric patient population?* *If no, is there a mechanism to track patient safety events in general? Is there an opportunity to include/pull out pediatric events?*	*What are others around the country doing to monitor and track pediatric patient safety events?*	*What could be done to improve here?* *Relevant Key Driver(s): 4-Processes & Policies*

6) Is there a mechanism to evaluate the event and implement improvements?	☐ Yes ☐ No

Key Elements / Considerations	Best / Suggested Practices	Possible Change Strategies
What is the process for this? *Is the process free of blame and focused on system-level improvements?* *If no, how are safety events evaluated? Does it relate to the culture of the organization?*	*What types of mechanisms do PECCs from around the country use to evaluate safety events?* *How do they implement improvements?*	*What could be done to improve here?* *Relevant Key Driver(s): 4-Processes & Policies*

7) What are the organization's strengths as it relates to pediatric patient safety and family-centered care?

What could be shared with others to help promote success? What could be leveraged to drive further improvement?

8) List the potential barriers to promoting pediatric patient safety and family-centered care at your organization.

How might these barriers be overcome? What support or resources are needed to overcome them?

9) Is there a specific change strategy that could/should be implemented at your organization?

Where would you start? What is the best first step to take to strengthen the role of the PECC?

KEY DRIVERS & CHANGE STRATEGIES

1. CULTURE

Crosscutting Change Strategies

1.1 Develop a process where leaders engage with staff to discuss potential safety threats.

1.2 Promote a "speak-up" culture where staff feels empowered to voice safety concerns.

1.3 Promote a blame-free culture where individuals freely report errors and near-miss events without fear of punishment.

1.4 Promote a culture where families are involved in shared decision-making and there is an attention to children's pain and anxiety.

Hospital-Based Providers

1.5 Develop a process where leadership routinely performs safety rounds on units, engaging and talking to staff about any safety concerns.

1.6 Develop a process of leader-based rounds where nurse and physician directors round on families to solicit feedback on how they feel pain and anxiety have been addressed as well as an explanation of the care plan to families.

1.7 Utilize a safety culture survey to identify opportunities for improvement in the organization (e.g., AHRQ's Surveys on Patient Safety Culture-SOPS®).

2. EDUCATION & AWARENESS

Note: Focus Area #5 is specifically dedicated to Care Team Competencies. This driver specifically refers to change strategies that promote patient safety and family-centered care.

Cross-Cutting Change Strategies

2.1 Develop materials that promote education and awareness about the unique physical characteristics, physiologic responses, and psychosocial needs of children with an illness or injury.

2.2 Identify training delivery modality for staff (e.g., a learning management system, PowerPoint slides presented during staff meetings, just-in-time education; peer-to-peer coaching).

2.3 Promote the integration of health literacy concepts and skills, including the use of plain language, the teach-back method, pictograms, and lower-literacy instructions

EMSC State Partnership Programs

2.4 Increase awareness of regional and national safety campaigns with which healthcare practitioners across the care continuum can engage (e.g., National Water Safety Month, Safe Kids®, Stop the Bleed ®).

2.5 Connect with your state/territory EMSC Family Advisory Network (FAN) representative on how best to engage patients and families in your region.

3. PRACTICES & PROCEDURES

Cross-Cutting Change Strategies

3.1 Ensure collection of a full set of vital signs (including temperature, blood pressure, heart rate, respiratory rate, oxygenation via pulse oximetry, and a pain score).

3.2 Utilize distraction techniques/items, education on comfort holds for children, education on adjunctive medications use for any painful procedure (intranasal medication delivery, topical gel for lacerations, topical pain control for IV insertion).

3.3 Develop processes for safe medication administration:

- use precalculated dosing guidelines for children of all ages. Consider promoting smartphone applications that provide decision support for precalculated doses.
- promote distraction-free zones for medication preparation
- practice vigilance for all administered or prescribed medications and consider developing standardized order sets, particularly for high-risk medications, such as opioids and antibiotics
- implement an independent 2-provider cross-check process for high-alert medications
- create a standard formulary for pediatric high-risk and commonly used medications
- standardize concentrations of high-risk medications
- reduce the number of available concentrations to the smallest possible number
- implement systems in which weight-based calculations are bypassed during pediatric resuscitations and treatment to reduce potentially harmful mistakes
- ensure that caregivers are well instructed on medication administration, particularly for pain and antipyretic medications.

EMS Practitioners

3.4 Ensure the use of a pediatric validated tool for weight *estimation* and documentation in kilograms only.

3.5 Develop dispatch pre-arrival instructions for children and families.

3.6 Ensure family-centered care is integrated into agency policies and procedures

Hospital-based Providers

3.7 Utilize a scale that only weighs—or can be locked—in kilograms only.

3.8 Develop processes for safe medication administration:

- consider adding a pharmacist with pediatric competency to the ED team, especially in large EDs, during times of higher volume
- implement and use computerized physician order entry and clinical decision support with pediatric-specific, kilogram-only dosing rules, including upper dosing limits, within ED information systems
- implement and use computerized physician order entry to create allergy alerts for all prescribed medications

4. PROCESSES & POLICIES

Cross-Cutting Change Strategies

4.1 Develop a process or policy that promotes safe medication administration (see driver 3 for specifics)

4.2 Promote overall patient- and family-centered care which includes:

- Using lay terms to communicate with patients and families
- Involving families in patient-care decision making.
- Having methods for accessing trained-language services to communicate with non-English speaking patients and family members (as opposed to bilingual relatives).
- Narrating actions and alerting patients and caregivers before interventions are performed.
- Allowing family members to remain close to their children during resuscitation activities and practice cultural or religious customs as long as they are not interfering with patient care.
- Allowing family members or guardians to accompany a pediatric patient during transport and/or transfer when appropriate and feasible.

4.3 A process for reported safety or near-miss events which includes a review of the event and identifies opportunities for improvement.

4.4 Develop a policy or standard format to ensure important information and findings are consistently relayed to the provider during all handoffs.

4.5 Ensure pediatric considerations are included in disaster preparedness planning and exercises, including tracking of unaccompanied children and timely reunification with caregivers.

4.6 Ensure pediatric specific screening questions are included in every evaluation including child maltreatment, suicide, and human trafficking.

4.7 Develop protocols for the mode of transport and/or destination of pediatric patients with consideration of regional resources and weighing the risks and benefits of keeping children in their own communities. Consider specific populations such as children and youth with special healthcare needs or those with behavioral health emergencies.

EMS Practitioners

4.8 Ensure there is a policy on the safe transport of children in ambulances.

4.9 Identify online medical direction from a physician with pediatric expertise that can provide support.

4.10 Develop a protocol to address the refusal of medical aid (non-transport decision making and documentation).

4.11 Where possible, consider engaging in mobile integrated health (MIH) and community paramedicine (CP) to provide patient-centered and integrated disease management and social services. A PECC can serve as a pediatric liaison within an EMS MIH/CP system to provide healthcare to children where they live.

Hospital-based Providers

4.12 Work with hospital health information managers on electronic medical record system optimization to recognize out-of-range weights and/or abnormal vital signs.

4.13 Direct families to appropriate resources and review patients' rights and responsibilities from the perspective of safety.

RESOURCES

TOOLS

1. Guide for Developing an EMS Agency Safety Program (NAEMT).http://www.naemt.org/docs/default-source/ems-health-and-safety-documents/nemssc/ems-safety-program-guide-10-11-17.pdf?status=Temp&sfvrsn=0.13715842522823762

2. National Pediatric Readiness Project Toolkit. https://emscimprovement.center/domains/pediatric-readiness-project/readiness-toolkit/

3. Prehospital Pediatric Readiness Project Toolkit. https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/

4. Patient- and Family-Centered Care Toolkit (EIIC). https://emscimprovement.center/education-and-resources/toolkits/patient-and-family-centered-care-toolkit/

5. Strategy for a National EMS Culture of Safety. https://www.ems.gov/pdf/Strategy-for-a-National-EMS-Culture-of-Safety-10-03-13.pdf

6. Pediatric Transportation Webinar (MD EMSC). https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/patient-medication-safety/safe-transport-pediatric-transportation-webinar/

7. Safe Transport of Children by EMS: Interim Guidance (NASEMSO).

8. Patient- and Family-Centered Care Organizational Self-Assessment Tool. https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/patient-family-centered-care/assessment-patient-and-family-centered-care-organizational-self-assessment-tool/

9. Comfort Positioning During Procedures: https://www.chop.edu/centers-programs/child-life-education-and-creative-arts-therapy/prepare-your-child-visit-doctor/comfort-positioning-during-procedures

10. Child Life 101 for EDs and Emergency Care Providers: Using Nonpharmacologic Methods to Manage Pain and Anxiety - https://com-jax-emergency-pami.sites.medinfo.ufl.edu/files/2016/08/EMD-01-Child-Life-101-Hendry-et-al_AC_8-10-16.pdf

TEMPLATES

1. The Ask Me to Explain Campaign: A 90-Day Intervention to Promote Patient and Family Involvement in Care in a Pediatric Emergency Department. https://pubmed.ncbi.nlm.nih.gov/27184244/
2. Pediatric Emergency ABC's and More (FL EMSC). https://com-jax-emergency-pecsi.sites.medinfo.ufl.edu/wordpress/files/2019/05/PEDReady-ABCs-and-more-ED-poster-with-code-05032019.pdf
3. Pediatric Emergency Prehospital Reference Guide (WI EMSC). https://www.chawisconsin.org/download/pediatric-emergency-pre-hospital-reference-guide/?wpdmdl=2406&refresh=5cf958b7350001559845047
4. Pediatric Reference Guide (NE EMSC). https://dhhs.ne.gov/OEHS%20Program%20Documents/EMSC%20Pediatric%20Reference%20Card.pdf
5. Sample Pediatric Transport Guideline (ME EMSC). https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/patient-medication-safety/safe-transport-sample-pediatric-transport-guideline-maine/
6. Sample Pediatric Transport Guideline (NH EMSC). https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/patient-medication-safety/safe-transport-sample-pediatric-transport-guideline-new-hampshire/
7. Wyoming Responders Safe Transport Initiative (WYRESTRAIN) Strategic Plan
8. Pediatric Resuscitation and Emergency Medications – Excel Calculator. https://emscimprovement.center/documents/991/Pediatric_Resuscitation_and_Emergency_Medications-Excel_Calculator.xlsx
9. Quick Reference Code Cards (UCLA Harbor Medical Center). https://emscimprovement.center/documents/682/Quick_Reference_Code_Cards2125_2.zip
10. Sample Medication Dosing and Intervention Cards (Michigan). https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/patient-medication-safety/medication-safety-sample-medication-dosing-and-intervention-cards-michigan/
11. Sample Pediatric Quick Dosing Reference (Colorado). https://emscimprovement.center/documents/1359/Sample_Pediatric_Quick_Dosing_Reference_Colorado__1.xlsx
12. FAMILY Survey Tool (English and Spanish). https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/patient-family-centered-care/assessments-family-survey-tool/

FURTHER READING

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3. Children's Hospital Association. *What Is Patient Safety?* 2021; Available from: https://www.hospitalsafetygrade.org/what-is-patient-safety.

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8. Emergency Nurses Association *Position Statement: Weighing All Patients in Kilograms*. 2020. https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/weighingallpatientsinkilograms.pdf?sfvrsn=9c0709e_6

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13. R.C., A., et al., eds. *Pediatric Care Coordination: An Interprofessional Resource to Effectively Engage Patients and Families in Achieving Optimal Child Health Outcomes*. 2nd ed. 2019, Boston Children's Hospital

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