Boston Children’s Hospital
The pedi-CSI (Clinical Safety Investigation): Virtual Patient Safety Rounds

Judith A. Vessey, PhD, RN, MBA, FAAN
Patricia Branowicki, MS, RN, NEA-BC
Peter Olivieri, PhD
Susan Shaw, MSN, MS, RN
Kristen Renaud, MEd
Starting with Patient Safety

- **Theoretical Support**
  - First step in quality care
  - Accidents are avoidable
  - Burden of injury
  - Understandable to providers, consumers, & payers
  - All participants could benefit

- **Pragmatics**
  - New professional mandates: Joint Commission and AACN
  - Student and new staff knowledge
Purpose: To develop a video-based library of patient safety vignettes that allows pre-licensure students to detect pediatric patient safety errors and vulnerabilities while developing ethical and critical decision-making skills needed to advance a culture of patient safety in pediatric settings.
Original CSI Vignettes

Patient Safety
Virtual Rounds
Community & Home Health

Pediatrics

ICU & Surgery
Project Rollout

Content Grid

- Mapping of Patient Safety Goals, associated problems, needed video, & debriefing scenarios

An Evidence-based Approach

- Review of VA vignette errors
- Literature review
- Data-based findings
- SERS report data
- Expert opinion
- Key MPS Patient Safety and Quality Committee
- Subject Matter Expert Groups
  - Mislabeled Specimen SME
  - Falls SME
  - Skin/Tissue Care SME
  - Electronic Surveillance and Resiliency SME (Monitoring)
- Radiology Department
- Child Life Services
- Environmental Services Department
Project Rollout

Content Grid
- Mapping of *Patient Safety Goals*, associated problems, needed video, & debriefing scenarios

Storyboard
- Scripts that contained defined elements; props, and actors

Filming & Editing
- Consent was obtained from all actors. Filming & editing of each vignette

Validation
- Content validation by expert panel

Dissemination
- Website being developed to host vignettes
Pedi-CSI Vignettes

- Falls
- Alarm fatigue
- Handoffs
- Mislabeled specimens
- High risk medications
- Cross contamination

- Housekeeping
- Transport
- Oxygen administration
- Medication administration
- Discharge planning
- Skin breakdown
Sample Vignette
Designed for Flexible Use

- As part of staff orientation programs
- In classroom settings to introduce key concepts
- In clinical conferences to discuss:
  - Monitoring personal behaviors and practices
  - Departures by colleagues from safe practices
- As part of simulation experiences

Appropriate for either individual or group learning
Features

- Vignettes initially are shown with the errors embedded but not labeled
- Vignettes are then shown again, with the errors labeled
  - Types of errors:
    - Errors of omission
    - Errors of commission
    - Situations are included that are frequently considered errors but are not
Examples of Errors

Errors of Omission

• No hand cleansing
• Insufficient patient verification procedures
• Failure to dispose of syringe; dirty clothes
• Failure for appropriate handoff

Errors of Commission

• Dangling jewelry
• Unnecessary gloving
• Making assumptions regarding family relationships
Questions for Discussion

- Whose responsibility was it for each of these errors?
- What do you do if you see a breach in patient safety that wasn’t your direct responsibility?
- How would you work with a UAP around safety training; safety errors?
Because this project draws on the complementary strengths and resources of academic institutions and clinical agencies, high quality, evidence-based, clinical relevant, pedagogical materials can be developed that are appropriate for multiple settings.
Support for this project came from:

- Boston Children’s Hospital *Program for Patient Safety & Quality* grant
- The Boston Children’s Hospital Parent Advisory Council
- “Friends & Family Philanthropic Foundation”
Bye, Bye!