The pedi-CSI (Clinical Safety Investigation): Virtual Patient Safety Rounds

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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

Differences in Pediatric Safety

CSI (Clinical Safety Investigation): Virtual Patient Safety Rounds

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
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
- Mislabelled Specimen SME
- Lab SME
- Skin/Tissue Care SME
- Electronic Surveillance and Resilience SME (Monitoring)
- Radiology Department
- Child Life Services
- Environmental Services Department

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

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

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

Appropriate for either individual or group learning
Examples of Errors

**Errors of Omission**
- No hand cleansing
- Insufficient patient verification procedures
- Failure to dispose of syringes; 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?

Summary

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.

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