These achievements reflect our ability to give every child the best possible care.

**U.S. News & World Report**

Children's National is ranked as the nation's #5 Best Children’s Hospital, #1 for newborn intensive care and is part of the *U.S. News & World Report 2018-19 Honor Roll*. Four additional Children's National services ranked in the Top 10: Cancer #7, Neurology and Neurosurgery #9, Orthopedics #9, and Nephrology #10.

**The Leapfrog Group**

Children's National Health System has been named a 2018 "Top Children's Hospital" by *Leapfrog Group*, an independent organization. This designation is given to hospitals with distinct achievements in patient safety and quality. Children's National is proud to have been recognized as a Top Children's Hospital 10 times and has received this distinction most often out of nearly 1,900 other pediatric hospitals since 2007.
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At Children’s National Health System, our mission is to excel at Care, Advocacy, Research, and Education. Our vision is to set the standard of excellence for the care of children. These Core Values define what we believe in as an organization and what we expect from ourselves in our work. Our goal is to make greatness happen every time, with every patient, and with every staff member in our organization.

Compassion
We serve all with warmth and kindness

Commitment
We lead with dedication and discovery

Connection
We team up for success
A Letter from our President & CEO

At Children’s National Health System, we’re committed to providing safe, quality health care for every patient at every visit. When it comes to quality and safety, the work never stops. We are dedicated to pushing one another to continuously improve, to tackle the most difficult challenges, and to share our learning with others.

We rely on a team approach and strive to create a culture of openness and honesty that encourages all employees, no matter their role, to speak up and do what is right, not just what is required. We understand that these measures are integral to delivering the highest level of care and helping each of our patients to Grow Up Stronger.

Every day, I am proud to see new partnerships evolve and innovative approaches implemented across our health system. With that in mind, we hope you will carefully read our latest Quality and Safety Report. In sharing our experiences and best practices, our goal is to further establish a collaborative community that partners to take pediatric patient care to the next level.

Kurt Newman, MD
President & CEO
We are excited to present our annual Quality and Safety Report. This past year has seen numerous improvements in the quality of care delivered while continuing to ensure the safest care for our patients. We continue to build on the culture of safety by training all staff on error prevention techniques and encourage robust reporting of safety issues. This year we approached employee and staff safety with the same rigor as we have with patient safety. Our quality outcomes are some of the best; however, we continue to push our care delivery teams to strive for zero harm. We know we can achieve this by continued engagement and novel approaches to improve the quality of care we deliver. We understand that what got us here today is not what is going to get us there tomorrow; said otherwise, we realize that to continue to deliver outstanding safety and quality improvements, we need to think differently. We have used the concept of pushing ourselves and our teams to climb the “quality tree” over the past couple of years. The best apples are at the top of the tree; we find that reaching the highest levels of quality and safety will take different, unique, sophisticated tactics – similarly to climbing an apple tree to harvest apples. When we approach quality improvement, we start with the low-hanging fruit which can be addressed by basic strategies and interventions. However, as soon as the low-hanging fruit is collected, we need to evolve our strategies to become more reliable (increasing levels of sigma) and climb the quality tree. We have simultaneously learned that for different initiatives (hospital acquired conditions or infections, etc.) we will be at different levels of the quality tree at any given time. We use this model to focus our efforts and most efficiently allocate resources to optimize outcomes for our patients. We are humbled to care for the most complex of pediatric patients and help them continue to Grow Up Stronger.

Rahul Shah, MD, MBA
Vice President, Chief Quality & Safety Officer
Sweet Fruit
5 σ Wall – Must Address Designs

Bulk of Fruit
4 σ Wall – Must Improve Internally

Low Hanging Fruit
3 σ Wall – Demand Improvement

Ground Fruit
Logic and Intuition
Significant efforts focused on improving perioperative quality and safety outcomes during 2017 - 2018. Jessica Cronin, MD led a perioperative quality improvement project aimed at reducing hypothermia in Neonatal Intensive Care Unit (NICU) patients undergoing surgery. Hypothermia in these patients is associated with significant morbidity and mortality, including difficulty breathing, cardiac problems, and abnormal bleeding. Before our interventions, clinicians noted that almost 10% of NICU patients returning from surgery were hypothermic, leading to medical complications and patient discomfort. Therefore, to improve patient outcomes and quality of care, we initiated a quality improvement project to significantly reduce hypothermia rates among NICU patients.

Anesthesiologists started monitoring the patient's temperature during the entire perioperative period and reported the incidence of hypothermia on a monthly basis to the Anesthesiology Department. Follow up occurred with individual anesthesiologists who cared for hypothermic patients to share feedback and guidance on preventing and treating hypothermia. With these interventions, we reduced the post-surgery hypothermic rate from 10% to 3%. This significant change improved perioperative care for our most vulnerable surgical patients.

Quality and Safety
Shireen Atabaki, MD and her team are at the forefront of a new approach to concussion treatment — one that stresses the avoidance of unnecessary Computerized Tomography (CT) scans. “A CT scan of the brain is meant to look for serious things like bleeding in the brain, but for concussions they are not helpful” Atabaki says.

What's more, radiation from CT scans can pose an unnecessary health risk. Children's National's approach replaces CT scans as the first line of diagnosis with a thorough, clinician administered screening tool. This tool serves as a checklist of clinical signs and symptoms. Atabaki estimates that the nation's health care system could save $500 million annually by eliminating unwarranted scans.

It can take 17 years for medical research evidence to become accepted practice. "That's a really long time to wait, so I decided to put this into the electronic health record, at the doctor's fingertips and at the patient's bedside.” Atabaki continued, "Within two months we saw a 30% decline in CT scans."
Antimicrobial Stewardship

Vancomycin, an antibiotic used for resistant gram positive infections, can lead to acute kidney injury and antibiotic resistance. It should be used judiciously when alternative antibiotics are available. Our Neonatal Intensive Care Unit’s (NICU) baseline Vancomycin prescribing rate was substantially higher than that of peer institutions. Our aim was to reduce Vancomycin prescribing rates in the NICU.

Interventions included development of clinical pathways to standardize empiric antibiotic choices for sepsis and necrotizing enterocolitis, pharmacy-initiated 48 hour antibiotic time-outs on rounds, and nursing and clinician education.

Using Plan Do Study Act (PDSA) cycles to drive improvements, Vancomycin days of therapy use declined while rates of Staphylococcus aureus bloodstream infections remained stable.
Reducing Readmissions
Leveraging the Electronic Health Record for a Safer Transition Home

Unplanned readmissions presented an opportunity to improve the quality of care delivered during and immediately after the discharge process. A team of Hospitalists, Case Managers and Performance Improvement staff observed increased readmission rates. Real-time access to the electronic health record allowed them to focus on relevant elements of the discharge and post-discharge processes to guide improvement efforts and reduce readmissions.

Unit-based interdisciplinary teams identified high-risk patients expected to be discharged on five or more specified medications. Case Managers and unit based pharmacists initiated medication counseling pre-discharge for these high-risk patients. Post discharge, Case Managers used follow-up phone calls with families to surface and escalate concerns and provide timely resources and interventions.

As a result of the improvements initiated, seven and thirty day readmission rates decreased by 29% and 15% respectively for our Hospitalist patients on one inpatient unit.

29% Reduction of Seven Day Readmissions
15% Reduction in Thirty Day Readmissions
95% Reduction in Pre-Discharge Work

Children’s National Health System
A Focused Approach To the Intake Process in the Emergency Department (ED)

Emergency Department (ED) visits in the Washington, D.C. metro area are 77% higher than the national average with wait times that are 64% longer. Children’s National triages more than half of those patients as mid to low acuity. Limited space and resources resulted in inefficient intake of these patients with long delays from triage to seeing a provider and to discharge. In January 2017, ED staff initiated a focused approach to improve patient flow and experience for these low and mid acuity patients by assembling a multidisciplinary ED-based taskforce. The aim was to decrease arrival to provider time for these patients and total ED length of stay for the patients.
5 Steps to Quality Improvement in the ED

1. Redesign Front Space
2. New Triage Assessment Process
3. Add 2 MDs to Front Staff
4. Increase Nurses to Front Staff
5. Data Updates for Reinforced Awareness

- 34% Decrease Time to Provider (low-acuity patients)
- 11% Decrease Time to Provider (mid-acuity patients)
- 5% Decrease ED Length of Stay (low-acuity patients)
A quality improvement (QI) team initiated a project in response to high rates of unplanned extubations (UE) in our level IV Neonatal Intensive Care Unit (NICU). Efforts to significantly reduce our NICU’s UE rates to <1/100 ventilator days initially began in 2010. Following the testing and spread of interventions which included real-time analysis of UE events, the rate decreased by 57% from 1.75 to 0.76/100 ventilator days. We sustained that rate from 2012 to 2015 during which a noticeable spike prompted a reinvigoration of QI efforts in this area. Interventions during this period included a reduction in daily chest X-rays (CXR) and development of a high-risk scale to help providers identify patients at potential risk for a UE. These interventions further reduced our rates by 42% to a mean of 0.44/100 ventilator days through 2018.

45% Reduction in Number of Single Chest X-Rays

$1.5M Projected Savings per Year
Unplanned Extubations

Unplanned extubation (UE) is a common problem in pediatric and neonatal intensive care settings that often leads to significant morbidity and mortality. Through the collaboration of our three ICU teams and Respiratory Care Services, we achieved a 27% decrease in unplanned extubations in 2018. Each ICU developed specific interventions targeted to its patient populations and shares these best practices with the hospital-wide team. Our NICU has achieved and maintains one of the lowest national NICU UE rates.

27% Decrease in Unplanned Extubations
Real-Time Data Drive Improvements

Rapid access to accurate clinical quality data is essential to operating a robust quality improvement program. The data are often compiled from disparate sources and are difficult to manage. Organizations have relied on spreadsheets for this purpose. Spreadsheets can become inundated with inconsistencies and the process of visualizing and distributing data becomes time consuming. The Quality & Safety Team constructed a process map of data structure and created an integrative model. This new data management system allows unit leaders to access real-time quality improvement data, allowing us to efficiently analyze metrics and develop effective quality initiatives.

Events Per 1000 Patient Days
Regression Trend: Jan 2015 - Oct 2018

42% Reduction (1.84 → 1.06)
Numerous high reliability industries use apparent cause analysis (ACA) to identify system causes of safety events. While standard methodologies exist to guide root cause analysis (RCA), ACA execution and quality vary greatly. Review of past ACAs highlighted barriers to identification of system causes and creation of strong action plans to prevent recurrence. The Patient Safety team restructured the existing ACA process to improve the analysis format, action planning, and follow-up.

The team implemented a multidisciplinary approach with direct facilitation by a safety consultant trained in cause analysis. Structured action plan monitoring takes place through a check-in call 30 days after the analysis and a report at the hospital’s Patient Safety Committee after 60 days. Standardized facilitation and group action planning improves the quality of ACAs without significant resource expenditure and promotes collaboration across departments and disciplines.

The new ACA process yielded advancements in safety. Notable process improvements included better meal tray processing for patients with allergies, redesigned high-risk equipment storage, hospital-wide training on MRI safety, development of new procedures, and independent checks for complex orders.

**Average of under 7 business days from event to scheduling the ACA**

**34 facilitated ACAs since implementation of the new process**

**20+ departments and divisions have been involved in the ACA process since**
In 2017 the Employee and Staff Safety Steering Committee reinvigorated organizational focus on reducing employee safety events in five key areas: verbal and physical violence, slips/trips/falls, sharps injuries, blood and body fluid exposures, and overexertion. We want all of our employees to feel safe so they can provide the highest quality care for our patients. Nursing leadership, educators, PR & Marketing, and a variety of other disciplines used quality improvement methods to reduce the number of employee safety events and ensure a safe place to work.

Handling Patients Safely

Lifting and moving patients are leading causes of injury to health care workers, yet potential injuries are frequently an accepted part of the status quo while providing direct patient care. In an effort to create a safe culture and eliminate these industry norms, the team joined the Employee Staff Safety Overexertion Pioneer Cohort with Solutions for Patient Safety in late 2017 and launched a Safe Patient Handling and Mobility (SPHM) program. This year’s accomplishments included:

- Launched a multidisciplinary team dedicated to preventing overexertion injuries
- Developed a Safe Patient Handling and Movement Policy and Procedure
- Established Employee and Staff Safety as a leadership priority
- Purchased friction reducing slider sheets and 2 new mechanical patient lifts
Preventing Slips, Trips and Falls

Slips, trips, and falls are a source of employee and staff injuries every year. A team lead by Nikolas Mantasas, Director of Environmental Services and Sustainability, developed a project to reduce falls by improving training, awareness, and equipment availability. The team created multiple interventions to prevent falls, including increasing the number of wet floor signs available and redeploying the “Lid On” campaign to remind people to cover their beverages. Interventions implemented since 2017 resulted in decreased slips, trips, and falls injuries. The team continues to test interventions to decrease injuries by an additional 10% in 2019.

- **35% Reduction**
  - Wet Floor Transition

- **25% Reduction**
  - Slips on Stairs

- **9% Reduction**
  - All Slips, Trips & Falls
Reducing Violence Against Staff

According to an Occupational Safety and Health Administration (OSHA) report in 2017, 75% of all workplace assaults occur in healthcare. A second OSHA report lists that workplace violence resulting in days away from work is four times more common in healthcare than in any other industry. Threats, hostility, and harassment are among the incidents reported, and nurses are most often the victims.

At Children’s National, we have seen a changing patient population. Victims of violence, patients under the influence, and those with behavioral health diagnoses requiring medical care are more common than in past years. With these patients comes a new set of challenges and higher risk for violent events. Increasing staff awareness of when and how to escalate when a potential safety issue arises is an important intervention to protect staff and patients.

Flyer
Circulated to Increase Awareness

Violence: Verbal & Physical

Violence is defined as either the threat of or an actual altercation between two staff members, a staff member and a patient, or a staff member and a visitor/caregiver.

Your Safety Matters, Too!

Reporting violence is a key part of your job – it helps to ensure not only your safety, but the safety of those around you. See below for what and how to report both verbal and physical violence.

Verbal Violence
- Name calling, obscene language, or other abusive behavior
- Intimidation through direct or veiled threats

Physical Violence
- Throwing objects
- Physically touching or intimidating

How to Report
- Report these events under the Employee Event/Worker’s Comptile in the Safety Event Reporting System (SERS)
- Select “Violence or threatening behavior” from the Specific Event Type drop down

Immediately report all acts of violence to the Security Operations Center 202.476.2065
Preventing Infections
Infection Control’s Commitment to Safety

The Office of Infection Control and Epidemiology (IC/E) is charged with preventing the spread of infections. The staff apply evidence based practices and work closely with the community, as well as local and national public health agencies to detect, respond, and eradicate threats to the health of our patients, visitors, and staff. Of the many infection prevention strategies, hand hygiene is the most effective method to interrupt organism transmission. In 2017, the IC/E team worked with clinical staff, Environmental Services, and Materials Management to successfully upgrade the hand hygiene program. The program now includes measures to monitor performance, revise protocols, and maintain communication. These efforts increased hand hygiene compliance from 63% to 92%.
Codes Outside the Intensive Care Units (ICU) 
Late Rescue Collaborative (LRC)

Early recognition of patient deterioration is critical in preventing non-intensive care unit cardiorespiratory arrests. Non-ICU arrests are associated with significant patient morbidity and mortality.

The LRC is an interprofessional program formed in 2013 to monitor non-ICU arrests, unplanned ICU transfers, rapid response team activations, and watcher activations. The LRC conducts monthly unit based meetings and monthly collaborative meetings. At these meetings, we monitor compliance with current escalation protocols, share lessons learned from reviewing cases, and evaluate new approaches to improve recognition and rescue of deteriorating patients. Through this work, we reduced the number of non-ICU arrests.

Children’s National Health System
The PRSC seeks to address safety matters directly impacting pediatric residents and their patients. The council collaborates with hospital leadership on safety initiatives to promote the highest quality patient care.

Although the concept of a residency safety council is not unique, the degree to which the Children’s National PRSC integrates itself into the safety culture is novel. By working across disciplines, the “resident voice” is heard and multidisciplinary partnerships are strengthened.

PRSC members regularly participate in cause analysis and spearhead resident driven safety improvements.
Error Prevention Training 2.0

The Quality & Safety Team launched a revised version of Error Prevention Training (EPT) to increase new hire engagement and skill retention. Enhanced EPT incorporates adult learning concepts through patient-centered storytelling, peer-to-peer discussions, non-clinical video examples of error prevention techniques, and technique teach-back sessions. The training program encourages new employees to interact with one another, share stories, and learn from others’ experiences. The interactive activities illustrate the importance of teamwork at Children’s National and establish each staff member’s individual role in keeping patients and staff safe.

In technique teach-back students act out scripts they’ve written to demonstrate their assigned safety technique.

“I AM A RETURNING EMPLOYEE.

I like how interactive the new training is.”

“The best thing about the class was the group portion where we acted out the techniques.”
In October 2018, Children’s National hosted a 10 day Quality Improvement Leadership Training Course focused on quality improvement principles and methodology. The project-based learning course featured presentations on hospital-wide quality improvement work and included speakers from the Quality & Safety Department, Nursing Quality, and the Neonatal Intensive Care Unit (NICU). The Performance Improvement team worked with the attendees on their own projects, such as reducing antibiotic use and increasing family-centered care in the NICU. The attendees presented at the end of the course to their colleagues and to five hospital presidents visiting from China.

20 Neonatologists from 17 different hospitals from China were in attendance.
Adaptive Response Training

Adaptive Response Training is an interprofessional unit-based initiative focused on teaching frontline clinicians about quality and safety. Pre-course work consists of three online modules on Identifying and Reporting Safety Events, Apparent Cause Analysis, and Root Cause Analysis and Action. In the in-person simulation-based class, the participants watch a video of a simulated safety event, perform an Apparent Cause Analysis, and provide care in a patient scenario where teams can practice teamwork and communication skills. Key takeaways from the debriefings include communication, interprofessional team interactions, challenges in the work environment, and reporting safety events.

Since July 2018, over 1,000 registered nurses, faculty, fellows, residents, NPs, and PAs have participated in Adaptive Response Training. We continue to monitor safety event reporting trends, barriers and enablers, and staff engagement to determine outcomes of this project.
Driving a Culture of Safety

Measuring the culture of safety is a fundamental part of a robust patient safety program. Children’s National conducts regular assessments using the Safety Attitudes Questionnaire (SAQ) survey. This measurement tool is administered to thousands of Children’s National employees across dozens of clinical divisions, nursing units, and clinical support departments. The survey collects sentiments on 7 key domains impacting safety.

The “Safety Climate” domain is the keystone to a culture of safety. Children’s National has focused on improving the Safety Climate throughout its safety journey. Safety Climate is the value employees feel the organization places on safety. Activities such as our Daily Check-In call, event cause analysis, Error Prevention Training, and Adaptive Response Training keep safety on the forefront of Children’s National every day, from day one. A strong Safety Climate also comes from encouraging reporting of events so improvements can be made. Children’s utilizes an online event reporting system to allow any staff member to voice a concern about safety. The system allows leaders to follow-up, track and trend events, and, starting in 2018, submit feedback directly to staff members through the File Tracker system. By focusing on encouraging reporting and learning from safety events, the Safety Climate domain scores increased by 10% over the past 3 years.

Percent Positive Response for the Safety Climate Domain

- 2015: 64%
- 2017: 69%
- 2018: 74%

10% Increase Over Two Surveys
Safety Culture Toolkit

Establishing a strong culture of safety is critical to providing high quality patient care. In 2017, the Patient Safety Team created the Safety Culture Toolkit to address the challenge of culture improvement. The team analyzed Safety Attitudes Questionnaire results to identify microsystems with improvements surpassing the organization’s average since 2015, coupled with overall scores exceeding industry benchmarks. Using the survey item scores and structured interviews with a focus on eliciting leadership best practices for improving safety culture within the organization, front-line staff and leaders identified key interventions for improving safety culture. Interventions around standardized communication, inter-professional integration, staff engagement, professional development, and transparency emerged as common themes among high-performing teams. From these interviews, a toolkit of Children’s National best practices was assembled for leaders to utilize when addressing safety culture improvement for the 2018 survey cycle.

“We think learning the importance of each team member and the challenges they face allows our team to function as a tighter group.”
Dr. Matthew Oetgen
Division Chief, Orthopedics

“We pride ourselves on being transparent and involving staff with decisions that can be make from a unit level as it pertains to recruitment and retention.”
-Maggie Finke
Nurse Manager

Children’s National Health System
Building Capability and Capacity for Quality Improvement

In 2015, Children’s National’s quality leadership determined that staff possessed varying degrees of knowledge of key elements to improve quality of care and outcomes. Aiming to build individual capability, we participated with Nationwide Children’s Hospital to educate clinical and administrative leaders on systematic improvement science methods in the Quality Improvement Essentials (QIE) course. Cohort participants use project-based learning to develop skills and use data to drive improvement.

Since fall 2015, over 40 staff traveled to Nationwide and completed the 4 month program. Six staff members are enrolled in cohort 8, beginning in January 2019.

Organizational capacity to improve quality in a systematic way is increasing. This Quality and Safety report provides examples of systematic improvement methods in use across the organization. As we continue to build individual capacity through training, our goal is for QIE graduates to coach and mentor colleagues to spread knowledge and use of improvement methods.

Over 40 QIE Graduates
Left to Right:

Monique Powell, RN: Increasing Medication Barcode Scanning in the Cardiac Intensive Care Unit
Rana Hamdy, MD, MPH, MSCE: Reducing Unnecessary Vancomycin Use in the Neonatal Intensive Care Unit
Beth Wells, MD, MHS: Improving Discharge Processes for Seizure Patients on the Neurology Ward
Jessica Cronin, MD, MBA: Getting to Zero: NICU Perioperative Euthermia
Nick Mantasas, MS, MBA: Dirty Room Bed Turnaround
Kathryn Jacobsen, MHSA, BSN, RN: Increasing Safety Event Reporting by Environmental Services
Left to Right Front Row:
Kirtida Mistry, MD: Improving Phosphorus Levels in Pediatric Dialysis in Patients >12 Years Old
Eva Rubio, MD: Decreasing Incorrect Abdominal U/S Orders
Susan Callicott: Decrease Percent of Same Day Surgery Patients (SDS) with ASA 1—2
Anit Saha, MSHA, MBA: Consultant
Evan Hochberg, MBA, RN, CPN: Consultant

Left to Right Back Row:
Tim Hayden: Reducing Theft of Employee Property on the Main Campus
Paul Manicone, MD: Increasing 6am—Noon Discharges on 7E
Rahul Shah, MD, MBA: Senior Leadership Panel

Not Pictured:
Christy Pomeroy, RN: Improving Patient Flow from Critical Care to Acute Care
Left to Right:

Kathleen Rigney, MSN, RN, CCM: Conditional Discharge Orders
Jacqueline Newton, RN, MSN, CPEN, NE-BC: Building a Safety Commitment with Families
Lori Crowder, MHA, BSN, RN, CNOR, FACHE: Reducing Cardiac SSI
Veta Ferguson, MBA, CPCS: Creating Overall Efficiency in Patient Safety and Provider Onboarding, While Eliminating Waste in the Turnaround Time of Credentialing
Catherine Forster, MD, MS: Reducing Empiric Antibiotic Prescription in Children who are at Low Risk for Urinary Tract Infections
Eric Balmir, M.S., PharmD, CIM: Improving Turn Around Time for IV STAT Meds
2018 Reducing Harm Heroes

Reducing Harm Heroes are found throughout Children’s National Health System. They are employees who have taken extraordinary measures to prevent harm.

February: In the IRU, Carolyn Rice, RN had been looking in the outpatient notes and realized that a fortification order was incorrect. The nurse notified the medical team and the order was changed.

February: Hellen Kiruthi, PharmD is a top-performing SPS champion. Her leadership and commitment during several PDSAs related to pharmacist led medication counseling, and her ability to engage both clinical teams and families has been instrumental in achieving a centerline shift in our readmission bundle compliance (48% to 79%).

April: Together with Dr. Amina Khan, Doctors Rebecca Shay and Maureen Banigan successfully initiated the Pediatric Residency Safety Council and have encouraged resident representation on committees and at safety meetings throughout the hospital. Residents receive patient safety education and an opportunity to participate in case analysis and safety projects.

May: Michael Shaw worked over the last two years in improving Error Prevention Training empowering hundreds of employees to speak up when they observe an issue. His personal stories are impactful to students and co-presenters alike. Michael sets the tone for the safety conversation at Children’s, and this has made our organization safer.

June: Bronwyn Parks BSN, RN, CEN, TCRN was caring for a seizing 2 year old when she noticed that the pediatric mask for the AMBU bag was unusually large. Melissa Pitts BSN, RN from the EMTC training team uncovered that the new Medline Resuscitation BVMs came from the manufacturer with a significantly larger size pediatric masks.

June: Laura Beth Lavette (above) was instrumental in helping the team revise Error Prevention Training to be more engaging and beneficial for the adult learner. Laura Beth’s tireless work in rewriting Error Prevention Training, as well as setting up classes and delivering the curriculum, has been exemplary.

August: Melvin Bray works for the Food and Nutrition Department as a cook and is also a Safety Champion and the Communication, Help And Training (CHAT) team commander. He teaches classes to the Food and Nutrition Department monthly and shares safety information.
October: Tejal Bhatt, RN (right) was checking morning labs when she noticed that a potassium bolus was ordered for her patient. She was concerned that her patient could potentially go into arrhythmia. Tejal called the resident and verified that the patient should not receive the bolus. Her attention to detail and use of a questioning attitude resulted in the safest care for the patient.

October: Security was asked to respond to the P1 level of the parking garage to investigate a report of an unattended child. Upon arrival, Children's National Special Police Officers recognized that there was a baby (later determined to be 10 months old) left unattended in a vehicle with windows up and doors locked. Temperature in the vehicle was estimated to be 90 degrees. Officers Brian Franklin and Chauncy Toler (below) forced entry into the vehicle by breaking the rear passenger side window opposite from where the baby was seated in his car seat. The baby was taken to the ED and was ultimately discharged back to the parents without any visible harm.

November: Josh Heffren, PharmD serves as the unit based pharmacist in the EMTC and his presence and proactive work ethic prevented a potential adverse effect. Josh went to a patient's room to double check the need of the particular medication. A visiting resident let Josh know that he had a syringe from several days ago that he was planning to use. Josh let him know that he could not use that medication and quickly went to grab another syringe for him to use, preventing the patient from receiving an old and likely contaminated injection.

December: While preparing to give Decadron prior to discharging her patient, Fausat (Bisi) Olowolayemo, RN noticed the change in color of the Decadron sent from Pharmacy as Decadron is normally light pink. Bisi immediately walked the medication to Pharmacy to verify the change in color. To meet the family's needs and due to the time constraint with getting the family out for discharge, Bisi requested the medication in tablet form, administered the medication and discharged the patient.
About Children’s National Health System

Children’s National Health System, based in Washington, DC, has been serving the nation’s children since 1870. We have created an environment in which care, education, and research work together seamlessly, simultaneously, and synergistically. Recognized for our expertise and innovation in pediatric care, Children’s National serves as a strong voice for children through advocacy at the local, regional, and national levels.

- **15,000 inpatient visits; 17,000 surgical procedures; 455,000 outpatient visits**
- **323 bed acute care hospital with 54 bassinet Level IV Neonatal Care Unit**
- **2 pediatric emergency departments, critical care transport program**
- **Ambulatory surgery center**
- **Community-based primary care network, 7 regional outpatient centers**

Children’s National Health System
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Washington, DC 20010
ChildrensNational.org