The Children’s Hospitals’ Solutions for Patient Safety (SPS) Network is an unparalleled, collaborative effort among children’s hospitals working to transform pediatric patient safety in pursuit of an urgent mission: to eliminate serious harm across all children’s hospitals. With support from the federal Partnership for Patients initiative, the Network grew from 8 hospitals in Ohio in 2011 to 80+ hospitals nationwide in 2014.

In 2014, 80+ hospitals worked to achieve a:

- 40 percent reduction in hospital-acquired conditions (HACs)
- 20 percent reduction in readmissions
- 25 percent reduction in serious safety events (SSEs)

Employing high-reliability concepts and quality improvement science methods in 2014, the SPS Network focused on reducing harm by preventing readmissions, serious safety events, and nine HACs, including:

- Adverse drug events (ADE)
- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated blood stream infections (CLABSI)
- Injuries from falls and immobility
- Obstetrical adverse events (OBAE)
- Pressure ulcers (PU)
- Surgical site infections (SSI)
- Ventilator-associated pneumonia (VAP)
- Venous thromboembolism (VTE)

Results

As of December 2014, the SPS Network had reduced the average rate of six hospital-acquired conditions—CAUTI, injuries from moderate or greater falls, SSI, CLABSI, ADE, and VAP.

Since 2012, this national effort has led to an estimated savings of more than $60 million and saved 2,500 children from serious harm.

The Network has seen the following reductions (from baseline to the current centerline):

- Falls: 81%
- VAP: 47%
- ADE: 42%
- CA-UTI: 25%
- SSI: 19%
- CLA-BSI: 11%
Progress in 2014

In pursuit of its goals, the SPS Network has built a robust data collection and analysis infrastructure; offers frequent opportunities to share and learn from high-performing hospitals; and engages a strong CEO leadership group to remove barriers to success and advise on strategic direction. In 2014, the SPS Network achieved the following:

Competing on safety has become a non-issue for Network hospitals
In less than three years, 80+ children’s hospitals from across the US joined together to share successes and failures transparently and agreed not to compete with each other on patient safety—ushering in a new era in pediatric patient safety that will accelerate the pace of improvement and save more children’s lives.

Evidence-based pediatric bundles distributed for HACs
SPS Network hospitals worked together to continue to standardize bundles in care delivery for each HAC for all pediatric hospitals, which are available publically on the SPS Website.

Senior leaders from hospitals engaged around their role in safety and quality
• Executive leadership is a critical aspect of successful improvement in pediatric patient safety. In 2014, SPS offered numerous opportunities for CEOs to come together to learn from one another and develop their safety leadership skills.
• CEOs pushed each other to all adopt the Daily Organizational Safety Brief.

Culture transformation journey continued with 60+ hospitals having completed or in the process of completing the culture change work
Network hospitals employ the cultural transformation strategies of other high-reliability industries to significantly reduce harm—measured by serious safety events (SSEs). This emphasis on creating a culture of safety within pediatric institutions is a unique aspect of SPS’s approach.

Patients and families partner with Network hospitals to help eliminate serious harm
Recognizing the critical role that patients and families play in safety, several Network hospitals reported that they have families as part of their HAC improvement teams and at hospital Board trainings. The SPS Network also incorporated families in its learning sessions.

Cross-Network teaching and learning fostered and national expertise spread
• SPS spread national expertise in pediatric patient safety by incorporating experts from more than half of their 80+ hospitals as teachers in their learning opportunities.
• From the start, SPS has offered numerous learning opportunities: nearly 225 webinars, more than 60 HAC-specific work group meetings, and four annual learning sessions, engaging 250–375 participants from throughout the Network at each session.

Looking Forward
With three years of learnings to guide SPS work and continued support from the Cardinal Health Foundation and SPS Network hospitals, the SPS Network is building on the Network’s approach in HAC harm reduction and culture transformation to continue the urgent pace of results achieved to date and keep even more kids safe from harm.

“I feel that our work with preventable harm is the most important work we do as a pediatric care delivery system...The SPS Network has given us focus on those areas of preventable harm that we can track with a larger cohort and community to learn from.”
~ Dr. Abraham Jacob, MD, MHA Chief Medical Officer, University of Minnesota Children’s Hospital
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