Children's Hospitals' Solutions for Patient Safety
Every patient. Every day.

SPS RECOMMENDED BUNDLES

To jump to a specific bundle, simply click on the link below:

Adverse Drug Events

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SPS Recommended Bundle

Table of Contents

Hospital Acquired Condition: ADE

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I. Background

ADE (Adverse Drug Events) is the 8th largest contributor to harm caused across the SPS network. These events include levels 6-9 or F-I. In 2011, approximately 15 children were harmed each month across the Phase I SPS hospitals. The team formed in May of 2012 to develop strategies consistent with high reliability concepts to reduce harm caused by ADEs.

II. Bundle Strategies - Overview

Develop Delivery System Intervention Bundle

1. Identifying High Harm Events
2. Review and catalog last 20 F & higher / 6-9 (NCC MERP Scale) ADE Events
3. Identify which medication delivery system the failure occurred
    a. Ordering
    b. Pharmacy
    c. Administration
    d. Monitoring
4. Determine top 1-2 factors that are common across those events (ie. Phase, Drug, Location, Failure mode, etc.)
5. Develop & Report 2-3 interventions (Hospital Specific Bundle)
6. Track impact on Hospital's 6-9 events

III. Bundle Elements – Evidence

Grade of body evidence: LOW

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IV. Bundle Elements – Standards of Care

To be developed at future data

Bundle Element	Standards of Care
Identifying High Harm Events	
Review and catalog last 20 F & higher / 6-9 (NCC MERP Scale) ADE Events	
Identify which medication delivery system the failure occurred	
Determine top 1-2 factors that are common across those events	
Develop & Report 2-3 interventions (Hospital Specific Bundle)	
Track impact on Hospital's 6-9 events	

V. Measurement- Bundle Reliability

Measurement	Formula	Recommendations	Reporting Period
Delivery System Intervention Bundle	Number of audits totally compliant with system failure bundle / Number of audits completed* x 100	*Apply formula to your hospital bundle elements.	Monthly

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VI. Tools

We have asked hospitals for some of their spotlight tools, and have highlighted a few in this folder. The highlighted categories are: Bundle Measure Methodology, PDSAs and Interventions, Risk Assessment, Training, and Failure Analysis.

Please click here to view the SHINE report.

VII. References

1. Franceschi, A., M. Tuccori, et al. (2004). "Drug therapeutic failures in emergency department patients. A university hospital experience." *Pharmacol Res 49(1): 85-91.*

2. Gandhi, T. K., S. B. Bartel, et al. (2005). "Medication safety in the ambulatory chemotherapy setting." Cancer 104(11): 2477-2483.

3. Kane-Gill, S. L., J. Jacobi, et al. (2010). "Adverse drug events in intensive care units: Risk factors, impact, and the role of team care." Critical Care Medicine 38(6 SUPPL.): S83-S89.

4. Tham, E., H. M. Calmes, et al. (2011). "Sustaining and spreading the reduction of adverse drug events in a multicenter collaborative." Pediatrics 128(2): e438-445.

5. Zandieh, S. O., D. A. Goldmann, et al. (2008). "Risk factors in preventable adverse drug events in pediatric outpatients." Pediatr 152(2): 225-231.

6. Unpublished, non-peer-reviewed consensus documents – CHCA, CDC

VII. Revision History

I. Version	Primary Author(s)	Description of Version	Date Completed
Version 1	Katie Hilbert	Initial Draft	7-Nov-2012
Version 2.0	Jason Bailey	Addition of sections III, IV & V	5 Feb 2013