Model can ID patients at risk for serious safety events

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Implementation of a system to identify and mitigate patient risk can reduce serious safety events among inpatients, according to a study published online Dec. 10 in *Pediatrics*.

(HealthDay)—Implementation of a system to identify and mitigate patient risk can reduce serious safety events (SSEs) among inpatients, according to a study published online Dec. 10 in *Pediatrics*.

Patrick W. Brady, M.D., from the Cincinnati Children's Hospital Medical Center, and colleagues reviewed recent SSEs and floor-to-intensive care unit (ICU) transfers. In an effort to decrease transfers determined to be unrecognized situation awareness failures events (UNSAFEs), an intervention was developed and tested to reliably and proactively identify patient risk and mitigate that risk through unit-based three-times daily inpatient huddles.

The researchers identified five risk factors that correlated with each event: family concerns, high-risk treatments, presence of an elevated early warning score, gut feeling of a watcher/clinician, and communication concerns. When using the model for improvement there was a significant reduction in the rate of UNSAFE transfers, from 4.4 to 2.4 per 10,000 non-ICU inpatient days over the study period. There was also a significant increase in the days between inpatient SSEs.

"A reliable system to identify, mitigate, and escalate risk can be implemented in a children's hospital and is associated with a reduction in safety events in a context where these events were already uncommon," the authors write. "Models to identify risk early and reliably intervene are likely generalizable both to different clinical systems and to modify different outcomes such as the patient/family experience and patient flow."

More information: Abstract
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