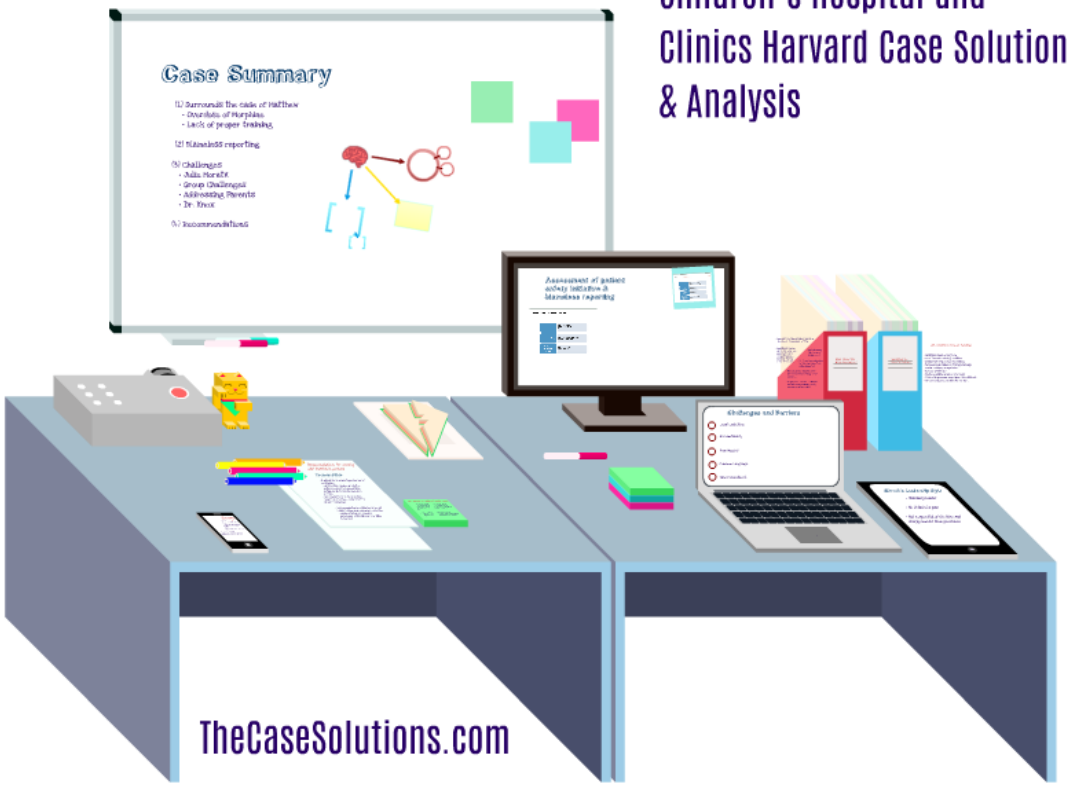
Children's Hospital and Clinics Harvard Case Solution & Analysis



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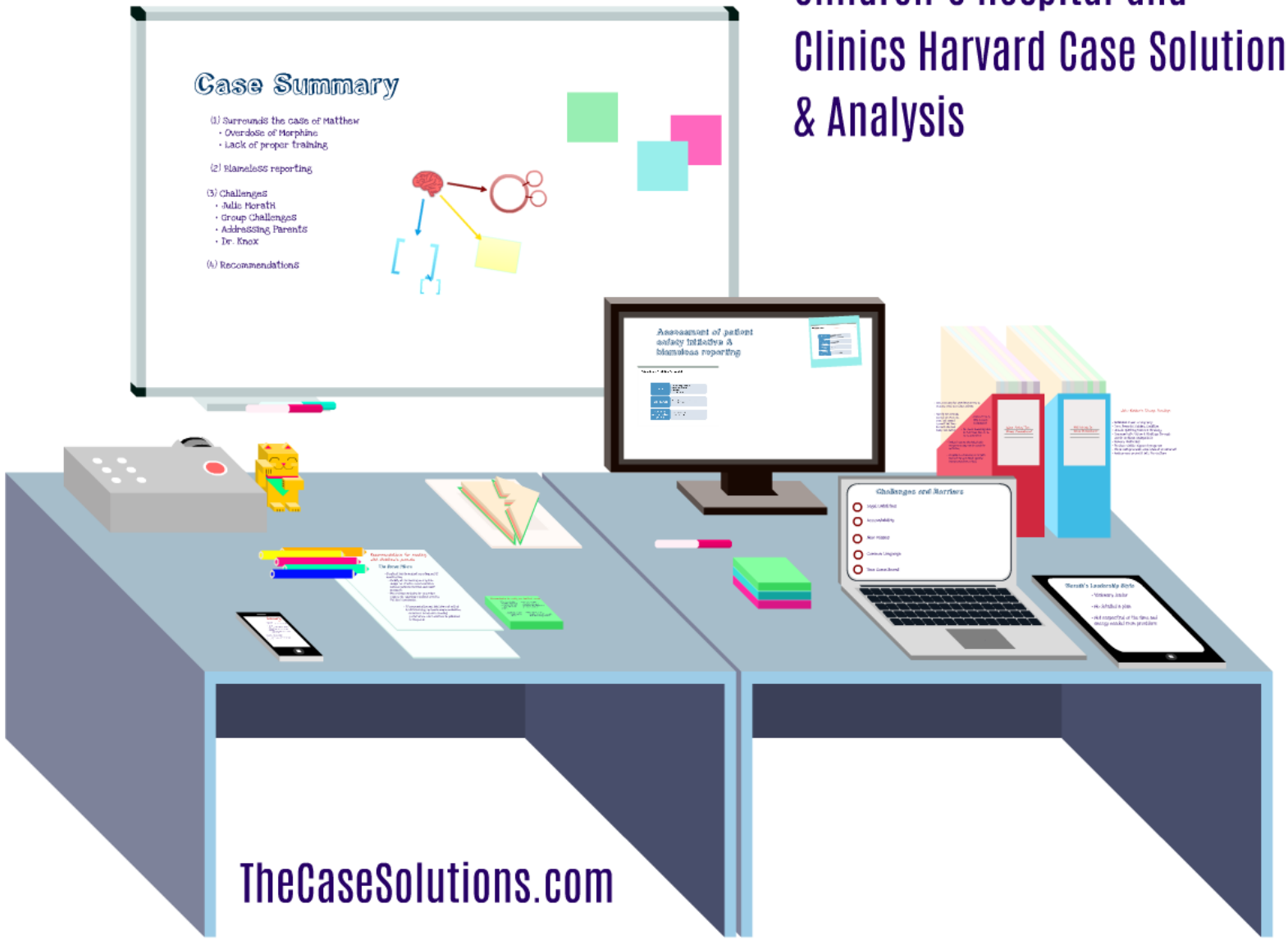

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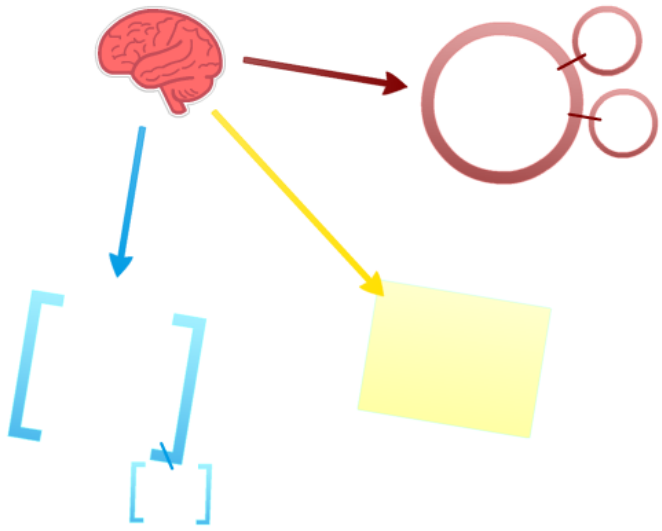
Case Summary

(1) Surrounds the case of Matthew
- Overdose of Morphine
- Lack of proper training

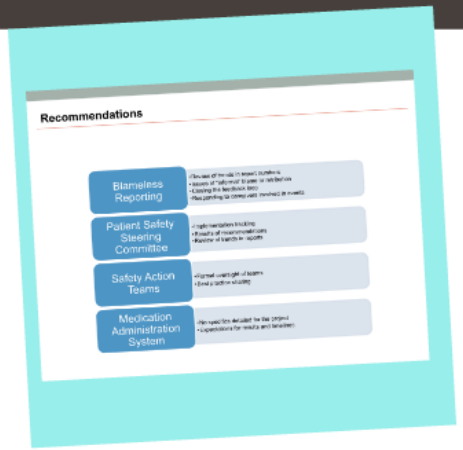
(2) Blameless reporting

(3) Challenges
- Julie Morath
- Group Challenges
- Addressing Parents
- Dr. Knox

(4) Recommendations



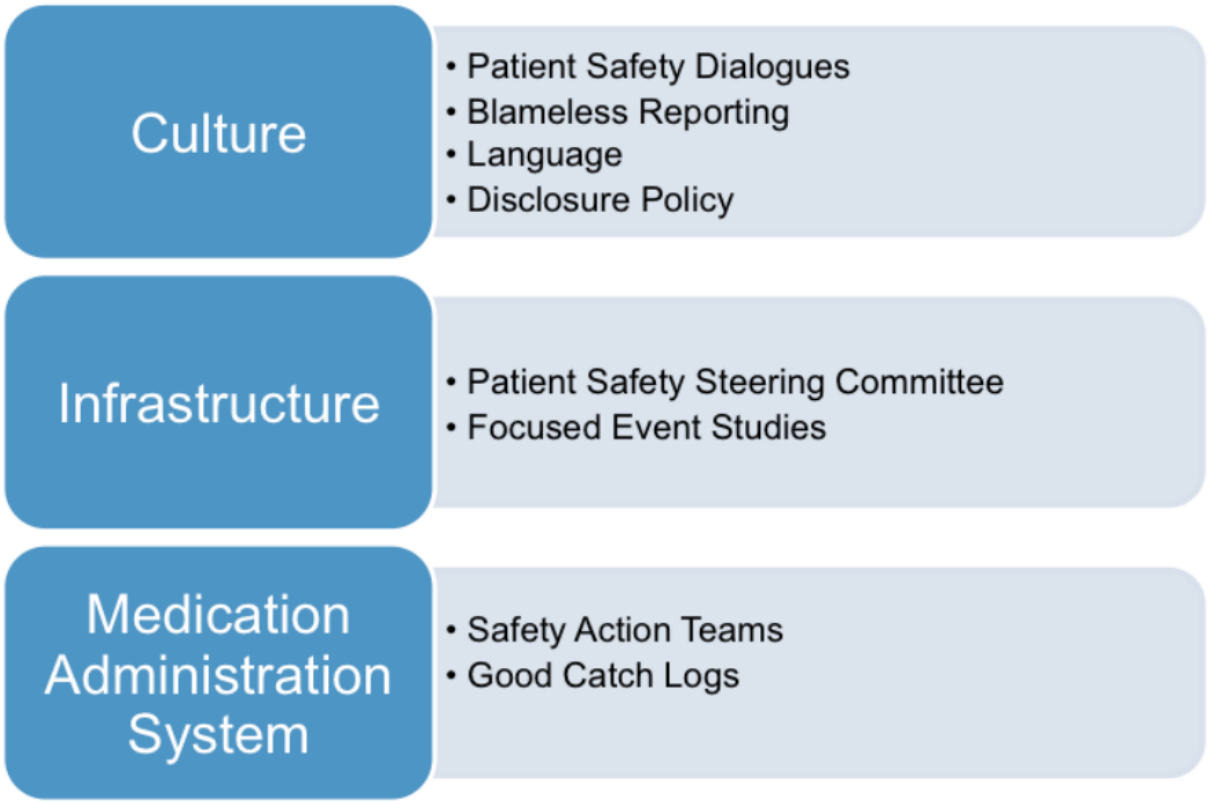
Assessment of patient safety initiative & blameless reporting



Patient Safety At Children's Hospital

Culture	• Patient Safety Dialogues • Blameless Reporting • Language • Disclosure Policy
Infrastructure	• Patient Safety Steering Committee • Focused Event Studies
Medication Administration System	• Safety Action Teams • Good Catch Logs

Patient Safety At Children's Hospital



Recommendations

Blameless Reporting	• Review of trends in report numbers • Issues of "informal" blame or retribution • Closing the feedback loop • Responding to caregivers involved in events
Patient Safety Steering Committee	• Implementation tracking • Results of recommendations • Review of trends in reports
Safety Action Teams	• Formal oversight of teams • Best practice sharing
Medication Administration System	• No specifics detailed for the project • Expectations for results and timelines

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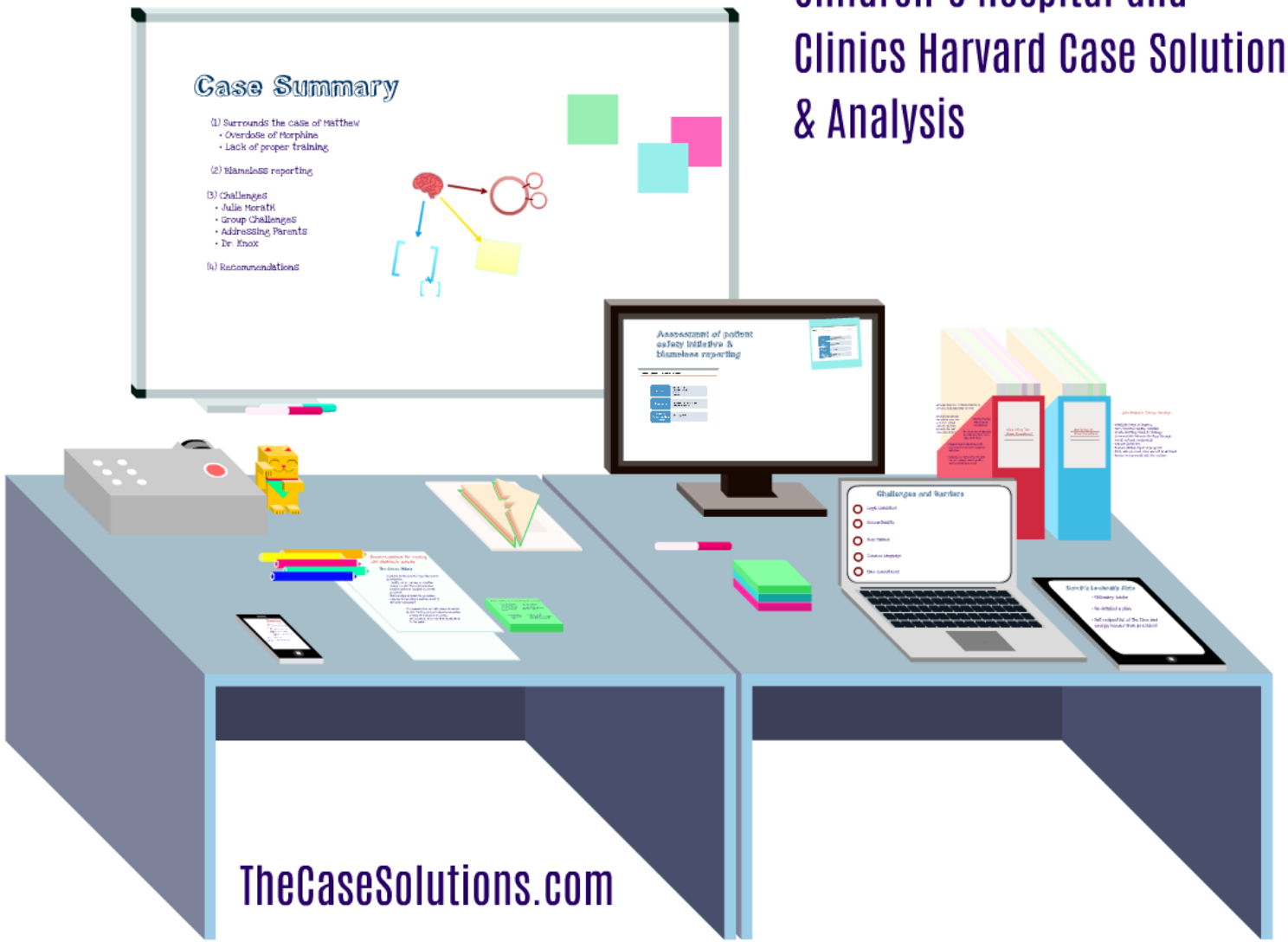

Challenges and Barriers

- Legal Liabilities
- Accountability
- Near Misses
- Common Language
- Time Commitment