Curricular Components That Support the Functions of EPA 5: Apply Science of Safety Concepts in Advocating Pediatric Patients Within the Hospital System

1. Knowing the common types and causes of pediatric patient safety events and common mitigation strategies
   - Knows the types of medication errors and risk factors that are unique to pediatric patients
   - Identifies and describes how system issues such as unwanted variability in care and failed communication impact patient safety
   - Names the common patient safety practices including order sets, practice guidelines, electronic health record (EHR), barcoding, time-outs, etc.

2. Using a shared language to promote interprofessional team-based patient safety behaviors
   - Uses common terminology such as harm, adverse medical event, preventable error, latent safety threat, reliability, situation awareness, shared mental model
   - Works effectively and collaboratively within the team to promote safety by reducing process complexity, building in redundancy, improving team functioning, and identifying team members’ assumptions
   - Consistently uses best practice communication within interprofessional teams such as closed-loop communication
   - Discloses safety events clearly, concisely, and completely to patients and caregivers

3. Applying tools to identify latent patient safety threats and address patient safety issues
   - Proactively identifies sources of potential harm including environmental and personal factors that affect ability to render safe care
   - Uses tools such as failure mode effects analysis (FMEA) and root cause analysis (RCA) to investigate potential or actual safety events
   - Actively contributes during ad hoc and sentinel event reviews
   - Participates in and leads quality improvement activities directed at enhancing the safety of hospitalized children

4. Promoting and role modeling a culture of safety
   - Describes the elements necessary for a culture of safety
   - Integrates safety principles and behaviors into daily processes of care and procedures (e.g., medication reconciliations, infection precautions compliance)
   - Engages patients and families in identifying and addressing patient safety threats to prevent harm
   - Uses the institution’s safety reporting system to report patient safety events
   - Explicitly calls attention to role modeling behaviors that promote patient safety
5. Advocating for pediatric specific patient safety initiatives at the unit, hospital, or health system level
   • Uses patient safety language and data to highlight patient safety threats and opportunities to institutional leadership
   • Identifies hospital environments or processes that lack an appropriate focus on children and takes steps to advocate for pediatric specific needs
   • Participates on key committees related to patient safety
   • Effectively escalates patient safety issues along the chain of command

Curricular Components Authors

Becky Blankenburg, Lindsay Chase, Jennifer Maniscalco, Mary Ottolini, Pediatric Hospital Medicine Fellowship Directors