CHILDREN'S HOSPITAL ASSOCIATION

CHILD HEALTH PATIENT SAFETY ORGANIZATION

Gap Analysis: Pivotal Points of Communication

Child Health PSO recommends reviewing your organization's case analysis on the topics of diagnostic safety and communication failures to determine how to best leverage the toolkit internally. The toolkit was designed to be used with any diagnosis in any unit/department.

Elements to Assess	Assessment Responses *Yes/No*	If *No*, what are your identified gaps/failures?	Action Plan(s)
A. Communication with Patient/Family			
A.1 Clinical interview and physical exam are performed in an appropriate setting and manner to enhance information gathering. Elements missing from the initial history and physical are explicitly flagged for later follow-up.			
A.2 Patients and families participate in a patient-centric, uninterrupted interview process to tell their story, which empowers family engagement and partnership.			
B. Communication Between Care Team Members			
B.1 Ongoing safety culture training is provided for all staff to ensure they can speak up and escalate concerns.			
B.2 Cognitive bias awareness training is provided for staff of all services and disciplines. Training may be deployed as a multi-phase process.			
B.3 A plan to address safety culture survey results is in place at the macro- and micro-system level.			

Elements to Assess	Assessment Responses *Yes/No*	If *No*, what are your identified gaps/failures?	Action Plan(s)
B.4 Standardized handover/handoff process precedes all transitions in care (e.g., shift change, patient transfer).			
B.5 Differential diagnoses are documented and prioritized for evaluation upon admission and updated with changes in patient status or new clinical data.			
B.6 Assessments are conducted to understand the care teams' comfort with stating "I don't know" when uncertain about a diagnosis.			
B.7 Expectations that outline when to defer to expertise (e.g., "must-call list") have been established, communicated and accessible to care teams.			
B.8 Escalation plans (e.g. watcher program) are established at the beginning of patient care and revised/reiterated at safety huddles/diagnostic timeouts occurring at varying times based upon other situations/clinical triggers for escalation. (See Page 3 for examples to consider.)			
C. Communication Regarding Laboratory Data/Diagnostic Imaging/Pathology			
C.1 External documents are reviewed upon admission (e.g., transferring facility records, diagnostic reports) and preliminary results are flagged for follow-up upon arrival.			
C.2 Standardized processes have been established to follow-up on all diagnostic test results, especially across care transitions.			
C.3 All values of diagnostic studies are reported, reviewed and interpreted together by members of the team.			

Examples to Consider

(these are not all inclusive)

When to Escalate

Formal escalation plan criteria

- Staff/family/patient concern
- Rapid Response Team (RRT) initiated in past 12 hours and remained on the unit
- Patients with a high acuity score (e.g., PEWS, PAWS, MEWS, CHEWS, Sepsis BPA)
- Q2 hour assessments/therapy/monitoring needed for > 4 hours
- Lack of response to treatment in expected timeframe
- Acute change in type or amount of output (including frank blood) from post-IR/surgery drains
- Any diagnosis not primarily cared for or rarely seen on the unit
- Patients with vital signs out of normal range

Other situations/clinical triggers for escalation

- Transfers (e.g., from outside facility, from floor to ICU)
- Change in level of care (e.g., patient deterioration)
- Lack of improvement and/or unanticipated deviation from plan of care
- Abnormal findings that don't make sense or could support competing diagnoses
- Uncertainty in diagnosis or diagnoses
- Change in medical condition (e.g., clinical triggers)
- Low-volume, high-risk situation
- Unable to perform procedure as planned
- "Gut feeling"
- Findings may draw the differential diagnosis into question
- Significant findings (e.g., perforated bladder, change in clinical status)
- Knowledge gaps (e.g., processes, diseases)

Who to Contact

Defer to expertise / who should be called?

- Nurse/ancillary staff to contact resident/fellow/attending physician/charge RN/shift supervisor
- Advanced practice provider to contact attending physician
- Resident/fellow to contact attending physician
- Specialty/service line attending (e.g., radiologist) to contact other attending physician (e.g., ED attending)

Participants in safety huddles or diagnostic timeouts*

- Patient/family
- Front line nursing
- Attending physician
- Primary care physician
- Specialty physicians/consults
- Resident/fellow/student
- Allied health care teams (e.g., respiratory)

** See Team Diagnostic Timeout resource*