Risk Assessments for Pediatric Emergency Transfers  
(AHRQ P20 HS17125-01)

Background  
The goal of this project was to conduct a prospective risk assessment at each of six Chicago Pediatric Quality and Safety Consortium (CPQSC) hospitals focusing on inter-facility pediatric emergency transfers.

Methods  
- The Emergency Transfers project consisted of conducting a Failure Modes Effects Analysis (FMEA) prospective risk assessment of the pediatric emergency transfer process at each of the six Chicago Pediatric Quality and Safety Consortium (CPQSC) hospitals. Led by Dr. Jane Holl, each FMEA was completed in collaboration with two referring hospitals.
- All participants involved in the FMEAs were knowledgeable about the issues related to transfer/transport of pediatric patients.
- FMEA methodology included: (1) describing the process; (2) mapping the process; and (3) documenting the failures.

Results and Conclusions  
- In total, eighteen institutions participated in the FMEA process. The receiving and referring hospitals who participated in this project represent a large percentage of the emergency services available to children in the local community of metropolitan Chicago.
- The FMEA completed at each institution generated a process map and an FMEA Risk Assessment Chart detailing the entirety of the pediatric emergency transfer process.
- For each FMEA, the Failure Modes, Failure Mode Causes, Consequences and Safeguards were identified and scored. All identified risks were then “binned”
into medium and high risk categories and further categorized by type of risk (e.g., communication, documentation). With the assistance of an experienced engineer in systems, safety engineering and safety analysis, the FMEAs were further evaluated for quality.

- Commonly identified issues in the process included: (1) inadequate transfer of information; (2) pending test/lab results delayed or do not arrive; (3) little or limited feedback; and (4) issues with referring hospital assessment.
- As part of the Leveraging Existing Assessments of Risk Now for Pediatric Patient Safety (LEARN) project, the FMEAs were evaluated to determine generalizable risks across Consortium sites. This allowed for identification of common failure modes and causes, which can serve as a foundation for developing patient safety improvements.
- Researchers developed a Standardized Pediatric Emergency Transfer Form in order to address commonly identified issues.
- For more information and to access the tools, please visit the Pediatric Emergency Transfers Toolkit.

Thanks to the support of: