

## Riverside University Health System Team Presentation

**OR Debrief Process** 

November 5, 2015



#### **Provider Enrollment**

## **High Reliability Operating Room**

Continuous - Evolving - Team



#### **Provider Enrollment**

- Reporting Culture
  - Just Culture

"Today's hospitals function in a reactive mode, investigating incidents in which patients have already been harmed, conducting RCA, and instituting corrective action plans to prevent future occurrences."

The Joint Commission



# **Best-Practice Baseline**

### Reporting Culture

- Just Culture
- Top Report Generating Department → Benchmarks
- ≥70% Pre-Incident

#### Baseline Data

- Baseline IR's: 11/month
- All Post-Incident



### **Implementation**

- Opportunity For Improvement → "OFI"
- Weekly Multi-disciplinary team meeting
- Results
  - Baseline Reporting: 11 IR/month
  - Executive Education
  - Initial Roll-out: 40/Month
  - RN, Surgeon, Anesthesia education
  - Current Reporting: >460/month



#### Results

- ID + Quantification
  - Equipment Mal-function
  - Equipment Shortages
  - Near miss patient safety events
  - Increased resources
  - Educational gaps
  - Patient flow improvement
  - Reduction in surgeon tardiness
  - Improved surgeon communication
  - Radiology process improvement
- Staff Morale



# Where we are going

Integration with efficiency metrics

Quantification of the \$\$ cost to institution

Integrate into quarterly OR drills



# The Value of Participating in the IE TeamSTEPPS Collaborative

Questions