Southern California Patient Safety Collaborative **Fast Facts**

Patient Safety First... a California Partnership for Health

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March 12, 2013–PSF Phase 2 Kickoff Meeting: Sepsis, Surgical Safety, Perinatal Safety, and HAI- C. Diff

132 attendees from 58 of our 76 PSF Collaborative hospitals learned about:

A Patient Story

Alice Gunderson, Patient Advisor

Having intimate experience as a family member when both her parents were patients at St. Francis Medical Center, and willing to be a caring, assertive, and helpful advisor to the hospital staff, Alice now serves as an instrumental advisor and advocate, both to patients and families, and to the hospital team as they continuously improve their patient-centered approach to care. Attendees learned the value of having Patient/Family Advisors.

The 2013 – 2014 Collaborative Charter

Julia Slininger, RN, BS, CPHQ- VP Quality and Patient Safety, HASC

A Collaborative Charter reviewing the 2013 goals was presented, outlining the clinical areas retained from Phase One: Sepsis Mortality and Perinatal Safety with a focus on eliminating Early Elective Deliveries, and introducing two new clinical areas: Preventing C. Difficile infection, and Surgical Safety with a focus on eliminating retained surgical items.

Measurement, Reporting and Web Portal Resources

Mia Arias, MPA, Director of Programs, National Health Foundation

Saleema Hashwani, PhD, HASC PSF Data Consultant

Measure specifications and the customized data reporting portal were reviewed, with a demonstration of how hospital teams can select and print their own graphic reports. Both Mia and Saleema are always available to our PSF hospitals for assistance with data collection or reporting.

Best Practices in Leadership - Strengthening Your Culture for Patient Safety

David Marshall, CEO, Safer Healthcare

The leadership focus of this presentation was on the importance of rounding with a multi-disciplinary team, AND having a mechanism to follow up on all the rich information that comes from the discussion and findings on those rounds. A tool was introduced that hospitals can use to capture and track follow-up on improvement action items.

Eight Clinical Breakout Sessions were attended by the hospitals' respective Clinical Topic Leads

Surgical Safety "Retained Sponge/Towel- A Never Event!" *Verna C. Gibbs, MD, NoThing Left Behind*	***Sepsis Management*** " Sepsis Management- High Tech & Low Tech" *Tara Crockett, RN, BN, MSC*
HAI- C. Difficile "Comparing the Guidelines" *Julia Slininger, RN, BS, CPHQ, HASC*	***Perinatal Safety*** "Avoiding the Undertow" *J. Patrick Lavery, MD, Coverys*

Surgical Safety "RSI Bits & Pieces and CHPSO as your Surgical Safety Partner" *Rory Jaffe, MD, MBA, Executive Dir., CHPSO*	**Sepsis Management** "EMCrit Podcast Review of the 2012 Guidelines- and asking the right questions" *Julia Slininger, RN, BS, CPHQ, HASC*
HAI- C. Difficile *"C. Difficile, the Misunderstood Pathogen"* *Alfonso Torress-Cook, Dr.P.H., Pacific Hospital Long Beach*	**Perinatal Safety** "A Community-Based Approach to Preventing Planned Deliveries Before 39 weeks" *Pamela Pimentel, CEO, MOMS Orange County*

The next meeting of the Southern California Patient Safety First Collaborative will be on July 16, 2013.