




Optimizing Performance and Patient Safety in the OR

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Safer Healthcare Partners with HASC

Our mission and vision is to create Perfect Patient Care™ by eliminating errors and waste from the delivery of care and increasing the quality of the patient experience.



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Perfect Patient Care™

Patient is treated error-free , on-schedule, without readmission, with the correct billing following the proper patient flow path with no workarounds.

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What is High Reliability?

Creating high reliability is about eliminating errors and increasing the predictability of quality in the delivery of patient care.

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High Reliability Organizations

A High Reliability Organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.

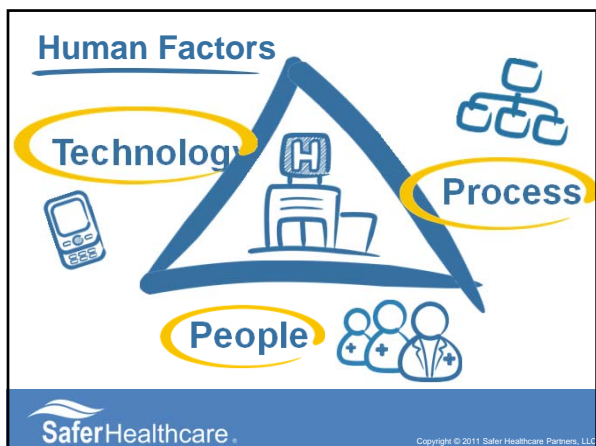
Event-free Operations

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2 Greatest Threats to HROs

- 1 Breakdown in Communication**
Gaps in the transfer of information
- 2 Normalization of Deviance**
Gradual shifts in behavioral norms

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Average Length of Stay.....4.8 days
Average Patient Handoffs per day.....5

4.8 X 5 = 24

That means 24 unique opportunities for a breakdown in communication that could cause harm to a patient. Multiply that by the number of admissions in your hospital and the risk to every patient becomes quite clear. While the number of handoffs can't be reduced, the risk associated with them can be – by applying a reliable system of effective communication.



Risk Profile

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Where Does Teamwork Fit In?

A team is distinctly different than a group.


Two or more people working toward a shared objective.




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Crew Resource Management

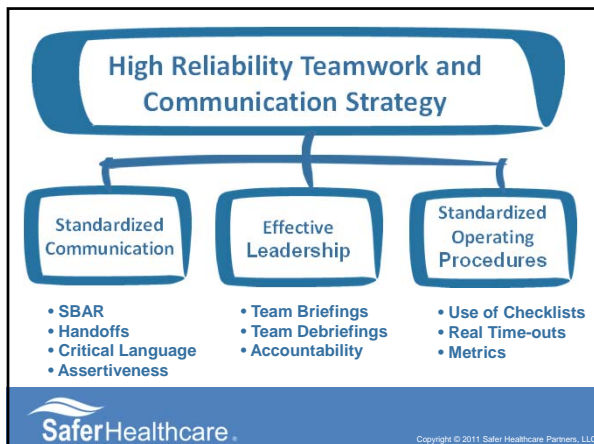


- Evidence-based System
- Consistent, Measurable, Uniform
- Not and Art. It's a Science.



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Team Briefings

3 Question Model

1. Introductions, first names (?)
2. Any special info about pt?
3. Any concerns, anesthesia or otherwise ?


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Team Debriefings

3 Question Model

1. What went well?
2. What did not go well?
3. What / how can we improve?

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What is Your Patient Safety and Quality Improvement Strategy to Create High Reliability Teams?



- 70% of TeamSTEPPS Initiatives Fail
- 90% of Lean Improvements Fail

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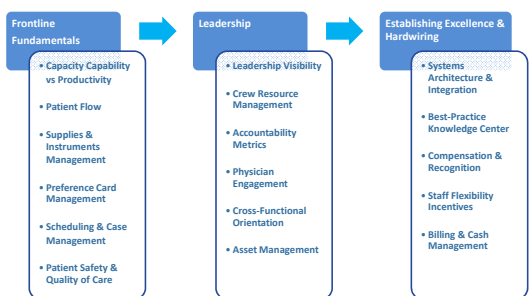
Patient Safety Culture



“It is easier to ACT your way to a new way of thinking than to THINK your way to a new way of acting.”

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Key Tenets of Perfect Patient Care



Frontline Fundamentals

- Capacity Capability vs Productivity
- Patient Flow
- Supplies & Instruments Management
- Preference Card Management
- Scheduling & Case Management
- Patient Safety & Quality of Care

Leadership

- Leadership Visibility
- Crew Resource Management
- Accountability Metrics
- Physician Engagement
- Cross-Functional Orientation
- Asset Management

Establishing Excellence & Hardwiring

- Systems Architecture & Integration
- Best-Practice Knowledge Center
- Compensation & Recognition
- Staff Flexibility Incentives
- Billing & Cash Management

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