Southern California Patient Safety Collaborative
Fast Facts

Patient Safety First...
a California Partnership for Health

Feb 26, 2015–PSF Collaborative Meeting: *Making Headlines in California!*

Our first meeting for 2015 drew 193 attendees from 76 hospitals. Feel free to review the various presentations in detail at http://www.hasc.org/southern-california-patient-safety-first-collaborative

Listen to your Patients, and Give them a Voice

Wray J. Ryback B.Sc., CPHRM, Patient Relations and Risk Manager, PVHMC, and Margaret High, Patient Advisory Council Chairperson at PVHMC

As the wife of a Traumatic Brain Injury patient admitted to PVHMC, Margaret helped staff members understand how a few simple provisions and considerations would make ALL the difference in her husband's initial recovery. At the same time, Wray was formulating the Patient and Family Advisory Council with zero additional staff members. Recruiting Margaret to help in the formative steps of the program's purpose and design was key, and PVHMC's Council is now 2 years old, and very effective.

Review of our Phase 2 Goals, Progress, and Action Plans!

Julia Slininger, RN, BS, CPHQ—VP Quality & Patient Safety, HASC

Quoting Don Berwick: "Some is not a Number, and Soon is not a Time", Julia helped hospitals appreciate the measureable goals that our PSF Collaborative AIMS to achieve by 12/31/2015. Each participating hospital was given a packet of data to help them see their own progress, compare it to the goal, and see where their performance falls in comparison to all other HASC area PSF hospitals on a de-identified bar chart. Those performing strongly were encouraged to mentor those still needing to improve.

Reducing OB Harm– Strategies & Resources from our Partners at CMQCC

Valerie Cape, Program Manager, CMQCC, Stanford University Medical School

Julie Vasher, Implementation Lead, CMQCC, Stanford University Medical School

Over the last decade, there has been a rise in the incidence of birthing mothers dying in the USA (1-2 per 10,000) and many more suffering severe morbidity. The goal of the California Maternal Quality Care Collaborative is to ensure that 100% of hospitals with maternity services in California are ready to respond to the two most common obstetric emergencies by implementing patient safety bundles for obstetric hemorrhage and preeclampsia.

Statewide Collaborative for Surgical Safety– Partnering with IPHI

Helen Wu, PhD, Institute for Population Health Improvement, UC Davis Health System

Under the Direction of Drs. Ken Kizer and Helen Wu, the Surgical Adverse Events (SAE) Advisory Council has met over the past year to analyze "never events" reported to CDPH from CA hospitals. These data demonstrated Retained Surgical Items (RSI) to be the most frequently reported event, and the SAE Advisory Group is about to publish its recommendations to CDPH and to the hospitals. A Surgical Safety Conference is scheduled for May 14-15, to which all CA hospitals are invited, and the PSF Collaborative will function as the follow up venue for continued focus on the SAE Surgical Safety recommendations.

Breakout Sessions featured other California Quality & Patient Safety Partners and Innovative Options

CHPSO "Safe Tables" Perinatal Safety Peer Discussion: Rory Jaffe MD, MBA and Claire Manneh, MPH
C. Difficile Prevention Strategies—A Year in Review: Suzanne Anders, HAI Director, HSAG
AFL 14-36 Requirements for Antimicrobial Stewardship, & Lessons Learned: Vicki Keller, RN,MSN,PHN,CIC
Sepsis Management "Simulation Training Practicum": Tara Crockett, RN, Director Clinical Delivery, MSC
Sepsis Improvement at Chino Valley Medical Center: Donna Young, RN, MBA, ARM, CPHQ, PI Director
Surgical Safety- "Applying Innovative Technology in the OR": Randy Saad, RN, Sr. Dir. White Memorial Med. Ctr.
Surgical Safety- "Using Adjunct Technology to Prevent RSI: Clyde Wesp, MD, Professor, USC