Southern California Patient Safety Collaborative
Fast Facts

Patient Safety First...
a California Partnership for Health

June 10, 2014–PSF Phase 2 Collaborative Meeting: Culture Trumps Strategy: Digging Deeper!

Our second meeting for 2014 hosted 142 attendees from 50 hospitals. Feel free to review the various presentations at http://www.hasc.org/southern-california-patient-safety-first-collaborative

The Hospital's Role in Safe Prescribing- Focus on the ER

Maureen McCollough MD, FACEP, Associate Professor of Emergency Medicine, UCLA School of Medicine

We have a new epidemic in our country: a Prescription Drug Abuse epidemic. Articles and Interviews in the Wall Street Journal, CNN Exclusive with Bill Clinton, and the Washington Post- as well as several medical journals, are helping us gain an appreciation of just how devastating this epidemic is. Los Angeles County Hospitals are implementing guidelines for Safe Prescribing of Opiod Medications, similar to guidelines adopted in San Diego. Toolkits were distributed to member hospitals who attended the breakout presentation for ER Nursing Directors.

Reducing Harm Across the Board- Strategies and Resources from our Partners in CalHEN

Bonnie Zell, MD, MPH, Executive Director of Clinical Improvement, CalHEN/HQI

Patricia Kirnon RN, BSN, MSM, CPHQ, Clinical Improvement Advisor, CalHEN/HQI

Great strides are being made by hospitals participating in California's Hospital Engagement Network, reducing harm in the 11 focus areas described in the CMS/HRET grant. Several toolkits have been created using successful strategies shared by peer hospitals, and posted to the HQI website for any/all hospitals to access. If your hospital is struggling with progress in any of the harm areas, http://www.hqinstitute.org/harm-elimination is your one-stop shop.

Cultural Diversity and the Patient Experience

Boris Kalanj, MSW. Director of Cultural Care and Experience, HQI

It starts with *empathy*- realizing that every patient, and indeed every person you come in contact with at the hospital where you work has a story- has a concern- has a need- that they have come to your facility for help with. We must add to that: *understanding*- about cultural, ethnic, and socioeconomic realities- that bring variation to each need. And to that we must add analysis of the variations before we can adequately create *solutions* to improve the patient experience. HQI will be assisting hospitals with this important goal using a directed and collaborative approach, enlisting as teachers and mentors, hospitals who have improved their HCAHPS data.

California Hospital Patient Safety Organization (CHPSO) "Safe Tables"

Rhonda Filipp, RN, MPA, Director of Quality and Patient Safety, CHPSO/HQI

Claire Manneh, MPH, Project Manager, CHPSO/HQI

CHPSO member hospitals engaged in a peer-protected discussion on safety risks in their hospitals, with a special focus on managing clinical device alarms and "alarm fatigue"

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

1. Surgical Safety "SAS Implementation Barriers / Strategies" *Verna Gibbs, MD, Professor, Founder NTLB*	***2. Sepsis Management*** Protocol Variation and Simulation Training Outcomes *Tara Crockett, RN, Director Clinical Delivery, MSC*
3. HAI- C. Difficile HAI Prevention- focus on C. Difficile *Kalvin C. Yu, MD, Kaiser Permanente*	***4. Perinatal Safety*** Addressing and Decreasing NTSV C- Sections *Elliott Main, MD, and Anne Castles, RN, CMQCC*