Southern California Patient Safety Collaborative
Fast Facts

Patient Safety First...
a California Partnership for Health

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**July 17, 2012–Track III: Perinatal Safety**

**On July 17th, 39 attendees representing 20 hospitals learned about:**

**Quantitative Progress- Reaching For Our Goal!**

*Julia Slininger, RN, BS, CPHQ, Hospital Association of Southern California*

Attendees were thanked for participation and data submission. Our collaborative goal is for each hospital to reduce early elective deliveries to <= 5% of all deliveries between 37 and 38+6 weeks. At last report, we had 27 hospitals meeting or exceeding the goal. Current reporting indicates 36 (65%) of our hospitals are now at or below 5%! The aggregate rate for all our reporting hospitals is now 2.47. "Eliminating early elective delivery" is the new language we are speaking.

**Physician and Nurse Champions - Eliminating Early Elective Deliveries**

*Hellen Rodriguez, MD, Director of Perinatal Services and Jeannie Badertscher, MSN, RNC-OB, Clinical Nurse Specialist, Pomona Valley Hospital Medical Center*

Utilization of a standardized pre-op note and pre induction consent are key to this hospital's consistent performance in preventing early elective deliveries. Any cases not meeting medical indications are reviewed by the champion and chair in real time before the cases go forward. The key question always asked by the Chair or Champion in these cases is: "What is best for the baby?" Posting data (blinded at first, then with MD names) on compliance rates was also key to success. Administration is completely behind the physician champions, so individual Obstetricians do not press their agenda beyond the OB Department protocol. For continued management of maternal and neonatal safety, Dr. Rodriguez strongly advocates for simulation training.

**Focus on the Mother: Post-Partum Emergencies**

*Larry Veltman, M.D., FACOG Risk Management & Patient Safety Institute*

The post partum unit often feels like the disregarded stepchild of the L&D service, but should not. The "golden hour" right after delivery, managing the neonate, several aspects of post-partum care for normal deliveries and for C sections, as well as being alert and skillful in maternal and newborn emergencies, are critical to obstetrical care. Communication strategies, teamwork, and accountability for all tasks are critical to a health post-partum episode. Rare complications were reviewed and discussed.

**Patient Safety Culture Survey: 2010 Results and 2012 Opportunities**

*Mary Ellen Filbey, RN, BSN, JD, CPHRM, Clinical Risk Management and Patient Safety Specialist*

45 of our PSF Perinatal hospitals participated in the AHRQ survey in 2010, 12 of which had 10 or more respondents. Key questions and outcomes (aggregate assessment) of the patient safety culture in those 45 hospitals were reviewed, with findings consistent between those hospitals with many respondents and those with few. Provisions have been made for a repeat survey to compare results with the 2010 baseline, which members can complete online through August 31st.

**Error Prevention: Is Your Program "All In" for 2012?- Chasing Zero Video and Discussion**

*Julia Slininger, VP, Quality & Patient Safety, HASC*

The video "Chasing Zero" was shared with an emphasis on how important it is to focus on the remaining potential for error, rather than the progress in performance. High Reliability Organizations keep their sights set on Zero errors. Every mother and newborn deserves our best.

***Presentations and additional materials from this meeting are available at www.HASC.org***