Southern California Patient Safety Collaborative **Fast Facts**

Patient Safety First... a California Partnership for Health

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October 23, 2012–Track III: Perinatal Safety

On October 23rd, 72 attendees representing 41 hospitals learned about:

AHRQ Perinatal Patient Safety Culture Survey – 2012 Results

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

Attendees learned about the Patient Safety Culture Survey results, comparing 2010 with 2012 findings. Many fewer hospitals participated in the 2012 survey, having already utilized other hospital-wide Patient Safety Survey tools. Key survey results underscored that several hospitals still have opportunities for improvement in supporting the "Just Culture" required to encourage reporting of near misses and errors.

Team Presentations

Antelope Valley Hospital – Elizabeth Dawodu and Gretchen Donohue
Citrus Valley Medical Center – Heidi Funk
Miller Children's Hospital – Connie von Kohler
Redlands Community – Maria King and Carolyn Arnold
St. John's Health Center – Irena Zuanic and Anne Heffernan

Attendees enjoyed learning the various approaches of these hospitals in their journey to reduce early elective deliveries. Each one had different lessons learned and strategies to share.

"T.R.U.S.T. Putting It All Together for Perinatal Safety"

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

Our subject matter expert, Dr. Veltman, gave us a new perspective on the most important elements in a culture for Perinatal Patient Safety, using an acronym for TRUST: Team training, Respect, Unambiguous conversations, Situation awareness, and Technical expertise. Each of these areas was then explored so that attendees could assess their own units' culture against these elements.

California Maternal Quality Care Collaborative (CMQCC)- Focus on Early Elective Delivery (EED)

Anne Castles, Project Manager, California Maternal Data Center
Terri Deeds, RN, BSN, NE-BC, Director, Women's & Children's Services, Saddleback Memorial Medical Center

The CMQCC has designed a more systematic way to submit data about Early Elective Delivery, utilizing the birth certificate records and coding data. One hospital who has used the system also shared their experience. Our PSF/SCPSC hospitals will have the opportunity to continue data submission as they are doing now, or switch to the CMQCC process.

2012 Accomplishments and the 2013 Horizon for Patient Safety First

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

Teams were collectively and individually recognized for their accomplishments, with 36 of 48 hospitals (75%!) receiving the award for reaching the goal of 0-5% EED, and 12 of 48 for reducing their EED rates toward the goal. Hospitals that have not been a part of the PSF/SCPSC project were invited to consider joining our Collaborative in 2013.

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