



Patient Safety First 2017 *Reality Check!* for Reliability

Julia Slininger, RN, BS, CPHQ
VP, Quality & Patient Safety, HASC
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Will this be a “Value Add” Day?

- *Add “stickiness” to your QI/PS outcomes*
 - Incorporate reliability objectives in the design of quality initiatives
- *Learn from our new Subject Matter Expert- Dr. Timothy Hannon*
 - Discuss the body’s response to blood transfusion, transfusion safety, and reliability
- *Understand the gravity of the CA edpidemic*
 - Apply standardized guidelines to opioid prescribing practices

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What do you do for a living?

I save lives

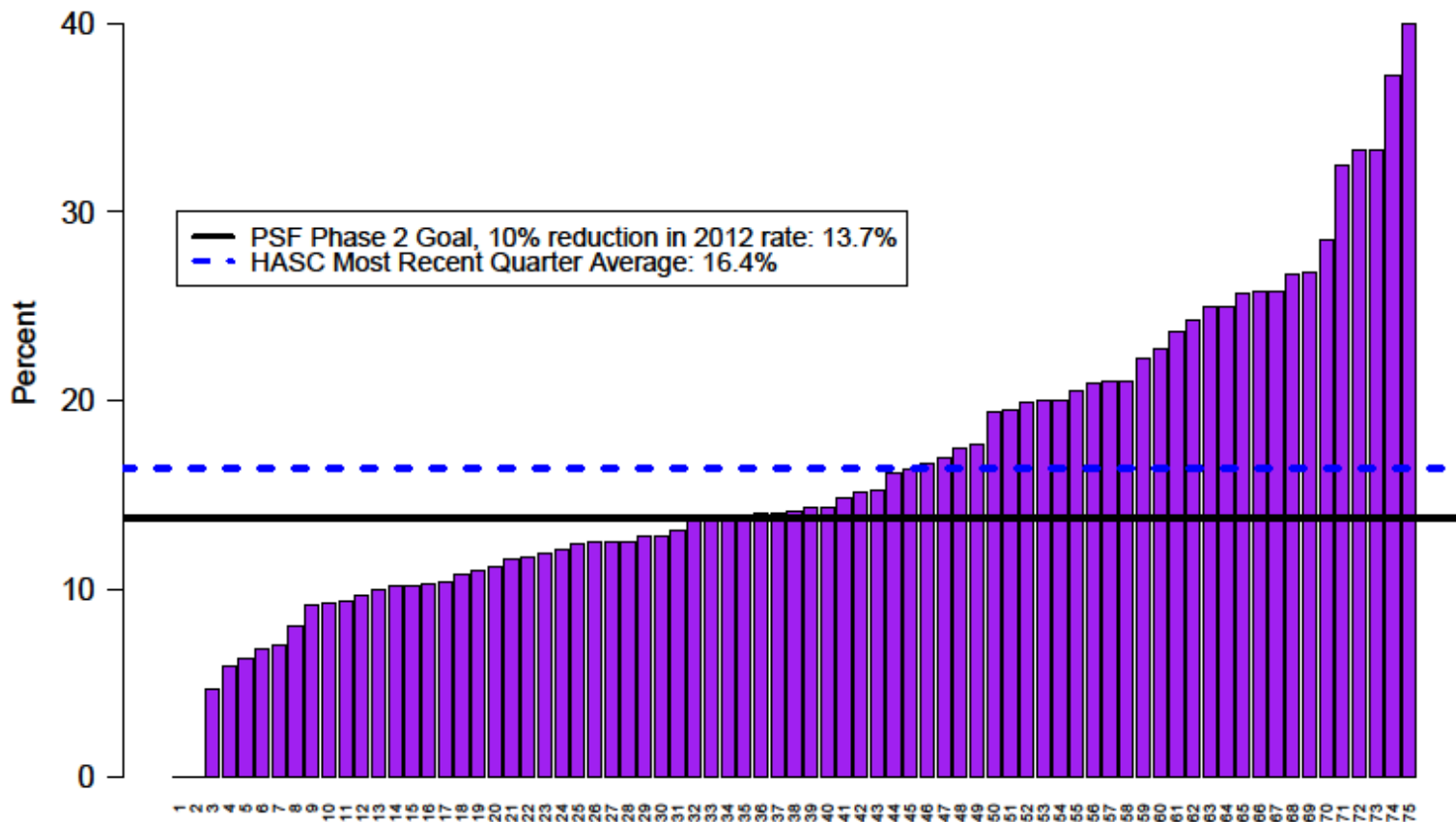
PSF 2.0 - 2017-2019

Thank You Anthem Blue Cross!

- Sepsis Mortality
- Transfusion Safety
- Enhanced Recovery After Surgery (ERAS)
 - *Handing off to CMQCC:*
 - *NTSV C- Section Reduction*
 - *Obstetric Hemorrhage*
 - *Handing off to HQI/Cal HEN*
 - *C. Difficile Infection prevention*

Sepsis Mortality

Sepsis Deaths per 100 Sepsis Cases
HASC Hospitals: Most Recent Submitted Quarter of Data



National Health Foundation, February 2015

Programming for Sepsis

- *Mentoring*
- *Simulation Training*

ERAS: Win, Win, Win

Facilitated Implementation

- Clinical Design Team (UCMCs +)
- Academic Resources for buy-in
- Implementation Toolkit
 - *Pre-Op, Intra- Op, Post Op*
 - *Helping you establish your internal team*
 - *Start with low hanging fruit*

Transfusion- Safety & Reliability

Facilitated Implementation

- Measure current performance
 - Usage and Wastage
- Address improvement opportunities
- Implementation Toolkit
 - *Low Hanging Fruit*
 - *Best- Practice interventions*
- *Win, Win, Win (Again!)*

FLEX
ZONE

DT
2
3
1
2

CHANGE

is good

you go first

OPEN

OPEN

OPEN

Use Existing Structures

- 1. Management Staff**
- 2. QI/ Patient Safety Committee**
- 3. Pharmacy and Therapeutics**
- 4. Medical Staff Committees**
- 5. Board of Directors**

New Team Members

- **QI/Patient Safety Director**
- **Perioperative Nursing Leader**
- **Transfusion Safety Officer/P&T Chair**
- **Other MD Champion(s)**
- **Executive or Board Member**
 - *Sun-setting content for HAI & Perinatal team*
 - *But we still LOVE YOU and need your support!*

Use Existing Structures

- 1. Utilization/Case Management Committee**
- 2. QI Committee**
- 3. Pharmacy and Therapeutics**
- 4. Medical Staff Committees**
- 5. Board of Directors**

Collaboration-

**“Everyone Teaches, Everyone
Learns”**

.....IHI- Don Berwick

**Introducing:
RUHS Medical Center**

High Reliability Organizing

**Zero Error
Goal Setting**

**Work through
barriers**

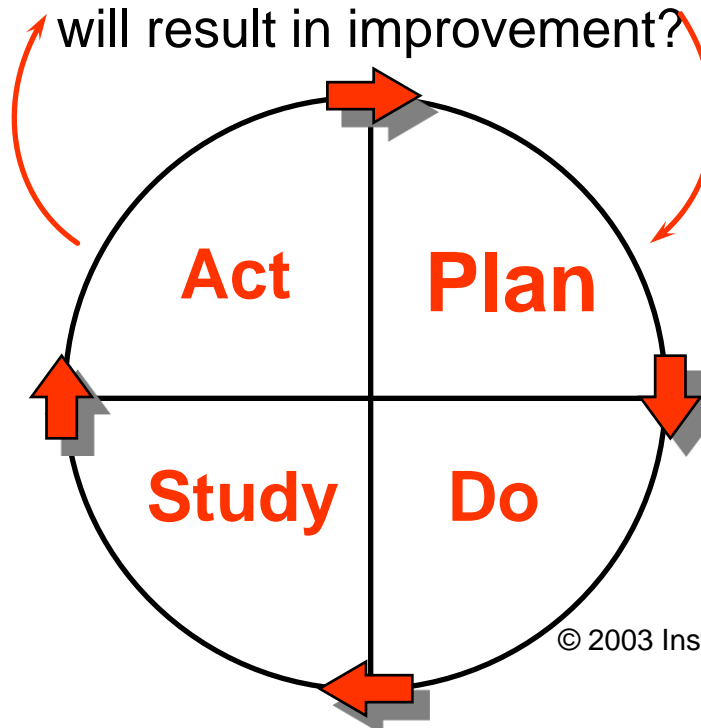
**Meaningful
Measurement**

IHI Model for Improvement

What are we trying to accomplish?

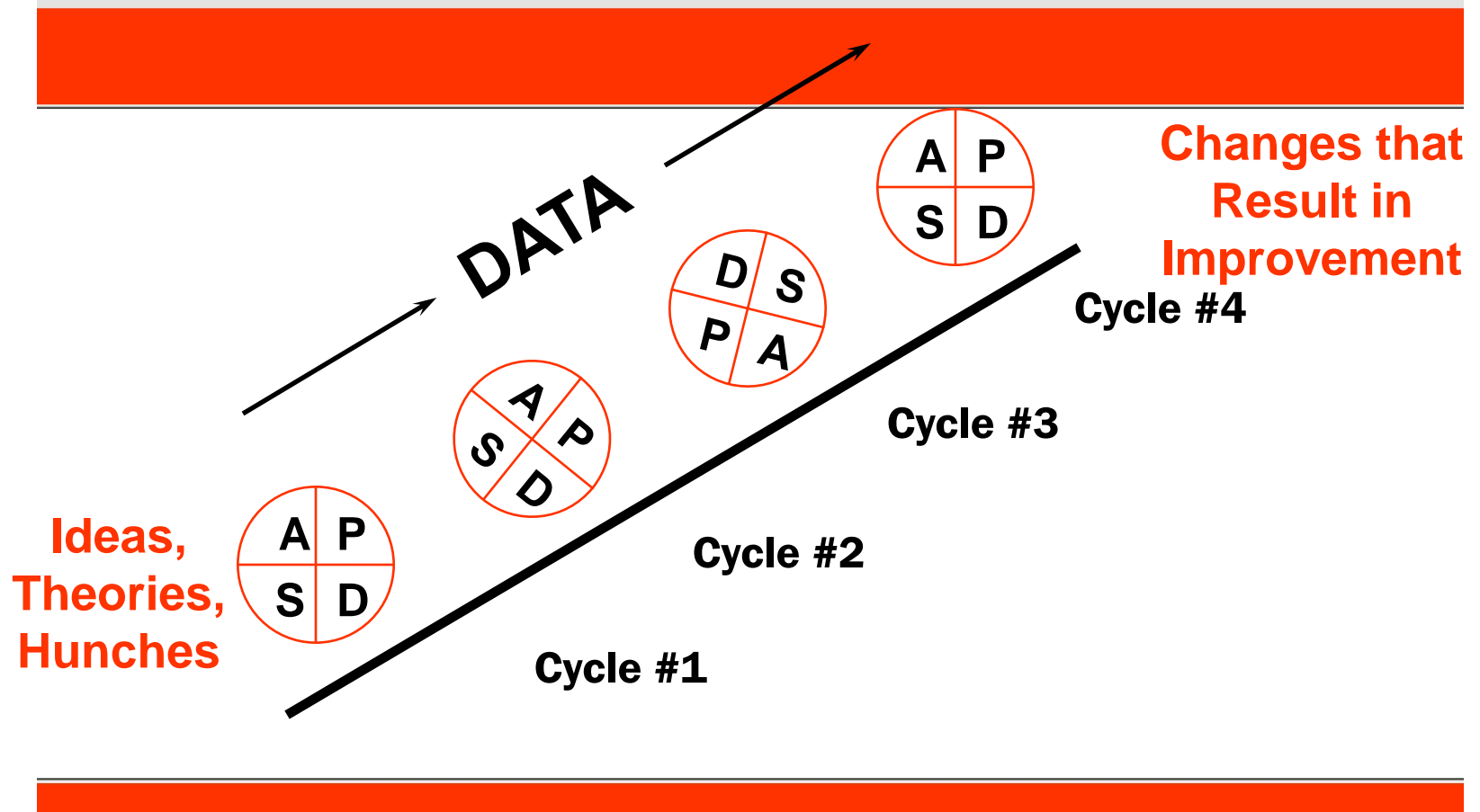
How will we know that a
change is an improvement?

What changes can we make that
will result in improvement?



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Use of the PDSA Cycle to Test Changes



Reality Check!

**Zero Error
Goal Setting**

**Work through
barriers**

**Meaningful
Measurement**

Place holder for Iceberg slides

...

Place holder for Iceberg slides

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Place holder for Iceberg slides

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Patient Safety First... a California Partnership for Health



Culture Trumps Strategy

You can't keep seeding the patient care environment with evidence based strategies ... if the soil (the culture) won't support their growth.



Hospital Quality Institute
Leadership in quality and patient safety



6 THINGS YOU MUST DO

- 1 Strengthen Your “Just Culture”**
- 2 Analyze Errors and Near Misses**
- 3 Personalize Harm**
- 4 Engage MD and Executive Champions**
- 5 Coach More than you Lead**
- 6 Build Teams**



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Save the Date!

November 2-4, 2016

Hospital Quality Institute Annual Conference

Hilton San Diego Resort and Spa

Learn more at www.hqinstitute.org/hqi2016



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