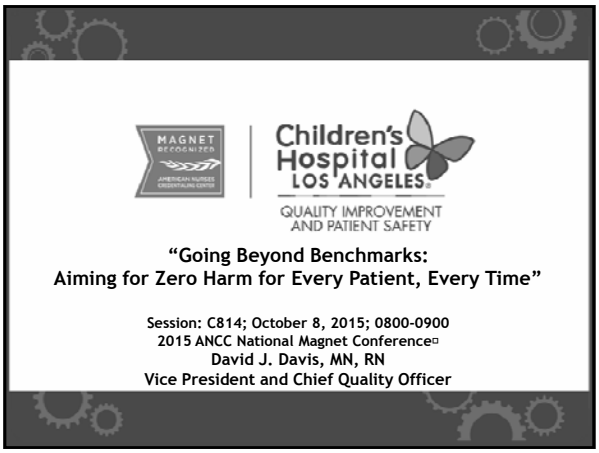


Session C814 Objectives

- Learn about a journey of transforming from a culture based in fear to one of personal ambition and "this is how we do it; this is the way we are wired."
- Discover how transformational leadership, both formal and informal, positively affects organizational change and commitment.
- Apply the philosophy of "going beyond benchmarks; zero harm for every patient, every time" versus "are we meeting or doing better than benchmark?" and the value in eliminating harm.

Session C814 Program Description

- Healthcare organizations have realized dramatic results in reducing patient harm by creating sustained, consistent outcomes with evidence-based measures.
- By going beyond benchmarks, learn how this quality improvement department, led by a transformational RN leader, has pursued zero harm for every patient, every time within an interdisciplinary patient safety effort.

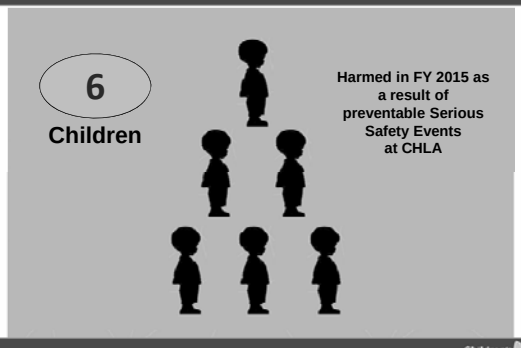
Burning Ambition to Burning Desire

1

Patient Safety Movement

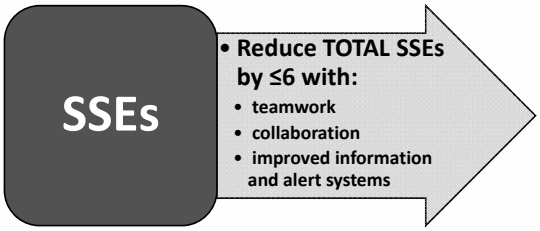
2

Organizational Internal Change Motivators



CHLA 2016 Quality and Safety Goals

Serious Safety Events (SSEs)



Patient Safety Basics: HACs

"Eliminate harm and provide the highest quality care in the most efficient manner possible."

- **Decrease events of and achieve 90% compliance with established Hospital Acquired Conditions (HAC) practice bundles**.
  - Adverse Drug Events (ADE)
  - Catheter Associated Urinary Tract Infections (CAUTI)
  - Central Line Associated Blood Stream Infections (CLABSI)
  - Falls
  - Pressure Ulcers
  - Readmissions (7 Day)
  - Surgical Site Infections (SSI)
  - Venous Thromboembolisms (VTE)
  - Ventilator Associated Pneumonia (VAP)

How do we use our event data?

- Reactive:
  - Events with potential or actual harm are reported via iReport
  - Investigation and corrective action related to event implemented
  - Evaluate events that actually caused harm to patient, after they occurred

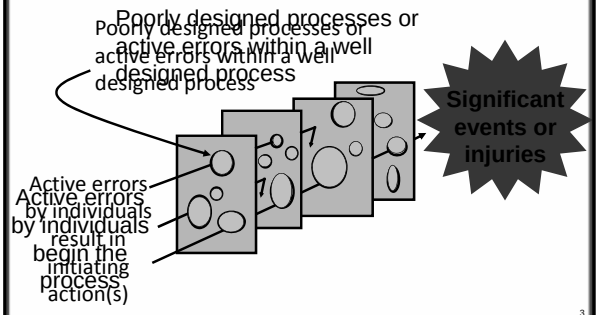
How do we use our event data?

- Systematic:
  - Reporting system monitored daily by quality department
  - Aggregate data and monitor for patterns or trends in harmful events
  - We evaluate how to fill in the gaps of our safety net systems and processes

How do we use our event data?

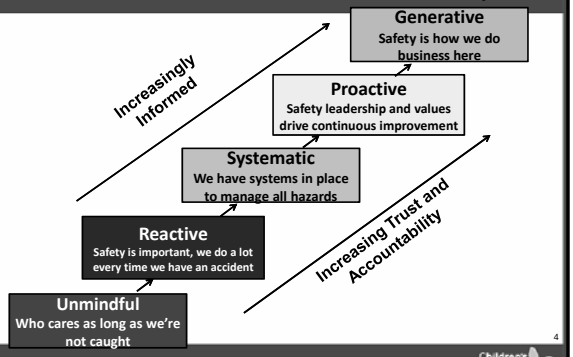
- Proactive:
  - Identify near miss and precursor events
  - Assess and evaluate how we can implement changes in our systems and processes before events occur

Swiss Cheese Model



3

Culture is Quantifiable and Can Be Improved



4

Organizational Internal Change Motivators

Creating a Robust Patient Safety Evaluation System

- iReport
- Focused Event Reviews (micro- and macro-system level)
- Root and common cause analysis
- Committee for Expedited Event
- and Root Cause Analysis (CEERCA)
- Quality Improvement and
- Patient Safety Committee (QIPSC)
- Medical Executive Committee (MEC)
- Safety and Quality Committee (SQC)

So how do we inspire personal ambition?

Our Vision for Patient Safety

We strive to eliminate harm with **humility** in our hearts and **resolve** on our minds.

Safe and Sound Curriculum

Patient Safety
- Leadership
- Team Dynamics
- Communication
- Speak Out for Safety (SOS)

Employee Safety
- Care of the Caregiver
- Therapeutic and Professional Boundaries
- Management of Aggressive and Disruptive Behavior (California Assembly Bill 508 Defensive Training)

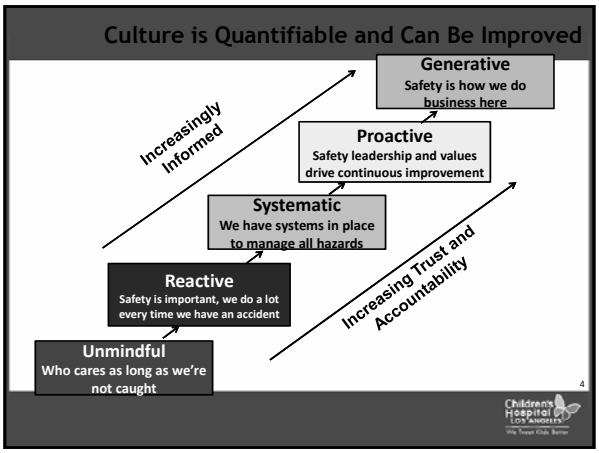
Igniting Personal Ambition

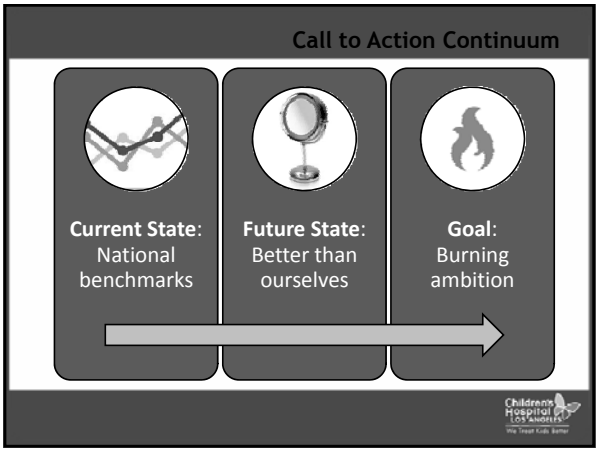
- "This session today was inspiring. All of you really engaged us, spoke to us about something that was relevant to our daily practice, and was meaningful to make things better. I felt like I could go back to my area with useful information."
- "Dr. Rivero was my favorite because she as a physician reached out to nurses and told them it was ok to be assertive and that it is important to question and make comments … that should be a new culture we adopt as collaborative caregivers."

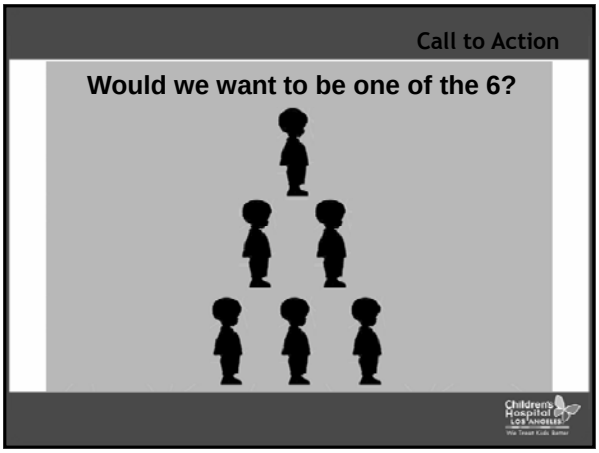
Furthering Our Organizational Ambition

- **Action Committee for Quality Outcomes (ACQO)**
  - Forum for leaders to share work/personal ambition as well as data and best practices
  - Enables and encourages education, mentoring, coa… problem-solving
  - Connects the dots among initiatives which … Experience
    - Performance improvement
    - Patient Safety
    - Research and Evidence-based practic…
    - Magnet designation
  - Multidisciplinary/Triad model
    - Physician Champions
    - PCS Champions
    - Quality Improvement and Patient Safety (QIPS)Consultants

2016: Develop Performance Improvement and Lean Program


Culture is Quantifiable and Can Be Improved
Generative
Safety is how we do business here
Proactive
Safety leadership and values drive continuous improvement
Systematic
We have systems in place to manage all hazards
Reactive
Safety is important, we do a lot every time we have an accident
Unmindful
Who cares as long as we're not caught
Increasingly Informed
Increasing Trust and Accountability
4


Call to Action Continuum
Current State: National benchmarks
Future State: Better than ourselves
Goal: Burning ambition


Call to Action
Would we want to be one of the 6?

Questions?

Works Cited

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