Patient Safety First...
a California Partnership for Health

Nov 5, 2013–PSF Phase 2 Collaborative Meeting: Sepsis, Surgical Safety, Perinatal Safety, and HAI- C. Diff

Our third and final meeting for 2013 hosted 128 attendees from 45 of our 81 PSF Collaborative hospitals

Learning from Experience: The Human Cost of Medical Errors

Christopher Jerry and Lisa Cappetta, the Emily Jerry Foundation

Emily Jerry was a 2 year old cherub who was winning the fight against cancer, but then died due to a medical error in the preparation of her final chemotherapy dose. Her father Christopher presented the story, outlined how and why the error occurred, and helped attendees focus on prevention strategies that start with supply management. Chiefly, it was surprising to learn that in many states, Pharmacy Technicians do not need to be licensed or certified in any way. The Emily Jerry Foundation is working nationally to change that, and to help us all learn from tragedy- to "let the healing begin".

Learning from Successful Strategies on a National Scale- Project Joints

Kathy D. Duncan, RN, Faculty, Institute for Healthcare Improvement (IHI)

This IHI project offers implementation support to a national network of participants on the recommended interventions to reduce hip and knee SSIs: Use of an alcohol-containing antiseptic agent for pre-op skin prep, Pre-op bathing or showering with chlorhexidine gluconate (CHG) soap for at least 3 days prior to surgery, and Staph aureus screening with use of intranasal mupirocin to decolonize staph aureus carriers. Individual hospital results were dramatic in reduction of infection, decreased cost and length of stay, increased patient satisfaction, and increased discharge to home.

Learning from the AACN- Six Essential Standards for Healthy Work Environments

Kelly McNeil-Jones, RN, Consultant

Silence Kills. Attendees reviewed seven concerns that often go undiscussed and contribute to avoidable medical errors. Work and care environments must be safe, healing and humane, respectful of the rights, responsibilities, needs and contributions of patients, their families, nurses and all health professionals. "Undiscussables" that are triple negatives: having Permanence, Pervasiveness, and a Perceived lack of control, represent key communication breakdowns that systematically prevent safety tools from protecting patients.

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

1. Surgical Safety "Analyzing Failures in Sponge Accounting" *Verna C. Gibbs, MD*	***2. Sepsis Management*** "Initiating MEWS in the ER- Identifying Sepsis Cases" *Jennifer Washington, RN BSN, CEN, Glendale Adventist*
3. HAI- C. Difficile "Hand Hygiene Program Design & Development" *Susanna Tung, RN, & the Alhambra Hospital Team*	***4. Perinatal Safety*** "Stemming the Increase in C Section Deliveries " *Lawrence Veltman, MD, Coverys*

1. Surgical Safety "Improving Team Dynamics" *Marco Navetta MD, Kelly McNeil-Jones RN*	**2. Sepsis Management** "CVP Monitoring: Theory, Effectiveness, & Alternatives" *Korbin Haycock, MD, Riverside County Regional*
3. HAI- C. Difficile Getting to ZERO with C. Difficile- a facilitated discussion *Julia Slininger, RN, BS, CPHQ*	**4. Perinatal Safety** "CMDCC Resources for your Perinatal Safety Program" *Anne Castles , CMQCC*