Healthcare Organization Commitment

Contact Details

Name
WILLIAM WILSON

Phone
714-456-6844

Email
wcw@uci.edu

Position
Chief Medical Officer

Organization Name
UCI Health

Organization Address
101 The City Drive South
Orange, 92868
United States

Commitment Details

How many hospitals are represented in this commitment?

<table>
<thead>
<tr>
<th>Last Report</th>
<th>Current</th>
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<td>1</td>
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Action Plan
In order to achieve your goal. Please provide as much detail as possible. UC Irvine Health has launched and institution-wide campaign to further strengthen our Culture of Safety as an element on our journey to becoming a high reliability organization committed to zero preventable harm and zero preventable deaths by 2020. The Culture of Safety Campaign is

Patient Safety Movement Foundation | patientsafetymovement.org
entitled: "Empowered To Make a Difference" in Patient Safety, Quality, and Engagement. To achieve this work we are focused on 4 main pillars of Safety and Quality: -- Implementation “TeamSTEPPS” - and evidence based program to improve communication between stakeholders --Development and implementation of the "Just and Accountable Culture Algorithm". This helps ensure a non-punitive reporting environment, increasing safety event reporting --Use of a “Patient and Safety Crosswalk” measurement tool to track safety and quality metrics used by: CMS Stars, Vizient, USN&WR, LeapFrog, NSQIP, PSMF, etc. --Leadership and participation in the PSMF Zero Lives by 2020 Campaign. On December 3rd, 2018, we launched the 5th pillar: Daily report out at Safety and operations Huddle days since the last harm and breach in hand hygiene.

Commitment Update
Specific actions include: 1) Rolled out a Campaign to change Culture from current state to a Culture of Safety 2) Conducted a Culture of Safety Survey 3) Used Results from the Culture of Safety Survey to develop a message to hospital stakeholders, and to inform corrective actions to make the hospital safer, and make the safety culture more robust. 4) Have developed multidisciplinary teams composed of MDs, RNs, Quality Experts, Pharmacists, Lab medicine, Radiology, Respiratory therapy, and other ancillary stakeholders, to review our safety data, and have asked these teams to develop corrective measures in their domains to improve safety and quality. We meet with these teams every 4-6 weeks to track improvements in safety and quality metrics. 5) Developed a TeamSTEPPS training program and began teaching this work. 6) Developed a Just Culture Algorithm for dealing with errors when they occur to increase reporting and increase the ability to make systems changes, rather than individual blame. 7) Developed a balanced scorecard (one for inpatient and one for ambulatory) that is now shared at Managers Forum, Director's Council, Medical Executive Committee to align all stakeholders on our institutional goal of Zero Harm to patients (especially by 2020). 8) We have a daily review of 100% of IRs that occurred in hospital within the prior 24 hours (72 hours for the Monday review). 9) We have a robust RCA and ACA review process of all IRs that come in or other systems errors that are reported to our critical event management team (CEMT). 10) Began a daily operations huddle that includes representatives for all hospital stakeholders - we lead off this meeting with requests for safety concerns. 11) We do 100% mortality review of all expired patients to search for safety factors.

Other
Challenge 1 - Creating a Foundation for Safe and Reliable Care

Please describe any best practices your organization has learned through your commitment and share valuable lessons or challenges that were overcome

UCI has made a commitment to improving patient safety, each of our leaders make themselves a part of the process by elevating awareness surrounding safety issues, evaluating patient safety interventions, tracking patient safety changes over time, setting internal and external benchmarks, and fulfilling regulatory requirements. In addition UCI leaders model a culture of accountability, which sets the tone for the rest of the
organization to follow suit.

**Impact Details**

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<tr>
<th>Initial Commitment</th>
<th>Commitment Update</th>
<th>Project Next Year</th>
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<tr>
<td>Lives Lost 551</td>
<td>Lives Lost 551</td>
<td>Lives Lost</td>
</tr>
<tr>
<td>Lives Spared Harm Target 0</td>
<td>Actual Lives Spared Harm in last 12 months 0</td>
<td>Lives Spared Harm Target for following calendar year 0</td>
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<tr>
<td>Lives Saved Target 57</td>
<td>Actual Lives Saved in last 12 months (might differ from initial target) 0</td>
<td>Projected Target of Lives Saved for following calendar to try to finish commitment 0</td>
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**Acknowledgement**

Yes, I acknowledge that this commitment may be used for external communication and publicly announced at the World Patient Safety, Science & Technology Summit. Furthermore, I agree that this commitment may appear on the website of The Patient Safety Movement Foundation or the Masimo Foundation. I also give permission for my commitment to be used in support of the promotion of the World Patient Safety, Science & Technology Summit as well as The Patient Safety Movement initiative.