

THE OPPORTUNITY

10 years ago, patient safety was a major problem nationally and in the San Francisco Bay Area (SFBA)



100K LIVES LOST EACH YEAR DUE TO MEDICAL ERRORS IN THE U.S.

High rates of sepsis mortality, ventilator acquired pneumonia, hospital acquired infections and medication administration errors



ZERO MAGNET® HOSPITALS

Not a single hospital in the SFBA was designated Magnet® by American Nurses Credentialing Center



QUALITY MEASURES BELOW NATIONAL AVERAGE

SFBA hospitals perform below average on federal measures for hospital quality and safety

BETTY IRENE MOORE'S VISION

Through her experience as a patient and caregiver, **Betty Irene Moore** saw the link between patient safety and Registered Nurses (RNs)

95%
HOSPITAL CARE
PROVIDED BY
RNs



patient per RN





OUR APPROACH

Improve patient care and outcomes through implementation of evidence-based practices by RNs



REGIONAL FOCUS

We've worked with:

52 (100%) ADULT ACUTE CARE HOSPITALS IN THE SFBA AND GREATER SACRAMENTO

9 (100%) SCHOOLS OF NURSING IN THE SFBA



4 KEY STRATEGIES

Ensuring a sufficiently large and well-prepared RN workforce

Implementing evidence-based practices in hospitals

Improving the transition of patients from the hospital

Supporting frontline nurse leadership

OUR ACHIEVEMENTS

80% SFBA

Reduced central line associated bloodstream infection to almost zero



each year from sepsis



30% of SFBA hospitals significantly reduced readmission rates



Magnet® hospitals increased from 0 to 4



More than
4500 RNs

1700+

RN graduates each year trained in quality and safety

100%

of **nursing schools** changed **curriculum** to include **quality** and **safety** 2500+

change agents developed with new leadership and clinical skills

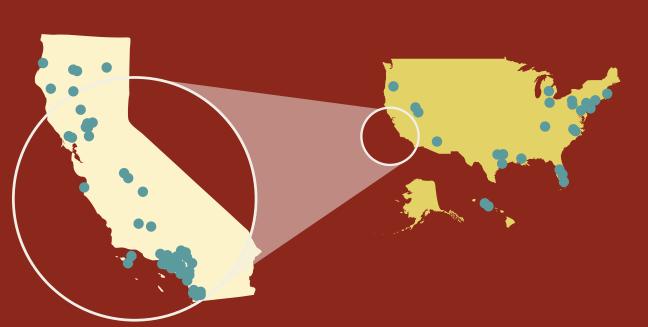
AND MUCH MORE...

*Data specific to SFBA; Sacramento area data available in 2015

OUR LEGACY

Betty's vision has had national impact through replication, publications, presentations and more, including the creation of a foundation program to eliminate harms for patients and families across the U.S.

70% of key projects were replicated elsewhere



MOORE