THE SAFETY LEARNING SYSTEM® COLLABORATIVE

Our community of 100+ healthcare facilities across Canada and the United States is redefining patient safety. Members consistently uncover that over 80% of improvement opportunities come from omissions in care—insights missed by traditional reporting methods.

We are naming, defining, quantifying and improving those process of care and system failures that contribute to the suffering and harm of our patients and frontline care team members.

> *This Collaborative allows me to feel like I'm doing my best to help improve the care of everyone, and it's not just the care of our patients but it's also the care of our providers."*
>
> - Shira Wolf, BSE | Collaborative Participant

This is more than just a research and learning collaborative. This a community of frontline healthcare team members and quality staff who seek to create a safe space for healthcare workers to research and create practical, meaningful, and lasting change without reprimands or misaligned incentives.

THE SLS COLLABORATIVE PROVIDES

Find up to 7x more opportunities for improvement compared to your current adverse event detection methods.

Access to the Healthcare Safeware® Web-Based Registry.

Learning from other Collaborative Member sites through benchmarking reports and monthly webinars.

Improve performance by targeting identified process of care and/of system failures.

Opportunity for scientific publications and presentations with fellow collaborators.

Training on proven case review methods and system improvement approaches for implementing change.

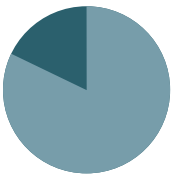
HEALTHCARE SAFETY SBC

hbhealthcaresafety.org

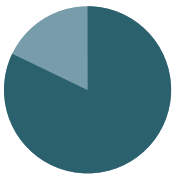
WHAT IS THE SAFETY LEARNING SYSTEM®?

Our Safety Learning System® is a holistic methodology designed to name, define, and quantify the broken processes and systems of care delivery that create daily challenges for frontline care team members.

Using a continuous loop of organizational innovation and learning, these system vulnerabilities and provider challenges are translated into Opportunities for Improvement (OFIs).



Traditional patient safety: Spend 80% of time, money, and energy on HACs & HAIs.



Collaborative findings: 80% of the opportunities of improvement are omissions - but less than 20% of opportunities are HACs and HAIs.

This system creates meaningful (understandable, measurable and improvable) knowledge, which is then used to inspire and influence leadership for lasting change. HBHS provides further training on how to inspire and influence leadership exclusively for Collaborative members.

Visible Events found with traditional Safety Event Reporting System

Hidden Opportunities for Improvement found with Safety Learning System

WHAT CAN I GET AS A MEMBER?

Community

Join the community of healthcare systems who are learning more and fixing more than ever before. Be supported by this community through regular role-based education, training, and coaching sessions as you implement and grow the continuous organizational innovation, improvement, and learning framework within your health system.

Ongoing Continuing Education Credits For Your Team

Get credit for the time you invest in your organization improving care outcomes. There are several opportunities including live online Collaborative Conversations (a monthly get-together for sharing lessons learned and obtaining new knowledge), live online training courses, on-demand courses, on-site training opportunities.

Healthcare Safeware®

This software was developed by Frontline care team members for Frontline care team members to support the ongoing naming, defining, and quantifying those process of care failures that impede our ability to deliver the best care possible every day. Utilize the standardized taxonomy and case review methodology only found in Safeware.

Data Analytics and Visualization Support

Safeware® will slice and dice your data in all the ways you can imagine. Six sigma analyses with visualizations to use for your reports and presentations.

FOCUS AREAS

Maximinizing Learning From Mortality and Other Case Reviews

Sepsis Care Improvement

Patient Transfers & Readmissions

ICU/Code Response Optimization

End-of-Life Care Enhancement

Length of Stay Management

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