Engaging Patients and Families as Safety Champions and Change Leaders

December 9, 2020
Rules of Engagement

• Audio for the webinar can be accessed in two ways:
  o Through the phone (*Please mute your computer speakers)
  o Or through your computer

• All hyperlinks on the screen are active if you click on them

• Q&A session will be held at the end of the presentation
  o Written questions are encouraged throughout the presentation
    • To submit a question, type it into the Chat Area and send it at any time during the presentation
Upcoming Team Training Events

**TeamSTEPPS for Change Leaders and Champions Online Course**
Over a 7-week period, this course will introduce participants to the TeamSTEPPS framework and tools and how to effectively manage change, build team resilience and integrate teamwork practices into existing workflows and organizational initiatives. [Register today](#) – limited spaces left!

*More virtual workshops and courses coming soon including Master Training.*
Today’s Presenter

Sue Collier, MSN, RN, FABC
Chief Engagement Officer
Patient Centered Innovation, Inc.
Today’s Objectives

Engaging Patients and Families as Safety Champions and Change Leaders

Explore the role of patients and families as safety champions and change leaders across the care continuum.

Describe at least one strategy to engage patients and families in effective team communication and mutual support.

Identify opportunities to engage patients and families as change leaders to improve safety culture, human resource management, and communication across the care continuum.
Objective 1: Explore the Roles
Safety Champion

• Passionate, active agents (or teams!) who lead by example and take initiative to reinforce a culture of safety

• Individuals willing to learn and engage with new ideas to improve care
Change Leaders

People with the ability to influence and inspire action in others, during growth and uncertainty
You are on the team!

Patient and Family Advisor or Advocate (PFA)
Patient- and Family-Centered Care

“A partnership among practitioners, patients, and their families to ensure that decisions respect patient's wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.”

Source: IOM, 2001

“An approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.”

Source: Institute for Patient and Family Centered Care

“Patients, families, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making – to improve health and health care.”

Source: Carman et al, 2013, Health Affairs
What Do Patients and Families Say About Patient Safety?

1. Communication and relationships have significant impact in the health care setting

2. Trust and expectations are shared emotions among patients, family and the health care providers

3. Patient-centeredness has meaning only when applied

Patient Safety: A Consumer’s Perspective

Richard B. Hovey,¹ Mitchell L. Dvorak,¹
Tessa Burton,² Sherry Worsham,¹ James Padilla,¹
Martin J. Hatlie,¹ and Angela C. Morck³

Abstract
In this article we provide a conceptualization of patient-centered health care practice through a collaborative person-centered model for enhanced patient safety. Twenty-one participants were selected and interviewed from the internationally diverse population of individuals attending the Chicago Patient Safety Workshop (CPSW) sponsored by Consumers Advancing Patient Safety (CAPS). Analysis of the participant transcripts revealed three findings related to patient experience: the impact and meaning of communication and relationship within the health care setting, trust and expectation for the patient and family with the health care provider, and the meaning and application of patient-centeredness. Researchers concluded that successful planning toward enhanced patient-centered care requires multiple perspectives, including the voices of the patient and family members who have experienced the trauma of preventable medical error. Collaborative initiatives such as the CPSW and CAPS offer a positive way forward for enhanced patient safety and quality of care.
The Patient’s Role in Safety

- In 2007, The Joint Commission mandated that health care organizations “encourage patients’ active involvement in their own care as a patient safety strategy”
- The Institute of Medicine report *Crossing the Quality Chasm* proposed that the individual patient preferences, needs, and values should guide all clinical decisions
The Patient As A Team Member

- Team-based care involves multiple players working with one another to improve outcomes.
- Team-based models reinforce patients as full participants in their care and health care professionals as capable of functioning to the full extent of their education and experience.
- Patients are the experts on their own care and lifestyle preferences.
The Patient As Safety Champion and Change Leader

• Patients are generally passionate, active agents who have a personal stake in their safety and efforts to prevent harm
• Many patients and families are willing to learn and engage with new ideas to improve their individual care - and the care of others
• Patients can influence and inspire action in others, during growth and uncertainty
• Patients that perceive their care team is working well together tend to report better experiences and perceive their care as safe and higher quality
Objective 2: Describe the Strategy
Patient Engagement: Levels and Settings

BEDSIDE/PERSONAL LEVEL
Settings: Inpatient room, outpatient care areas, rehab unit, clinic exam room, skilled nursing bed, ambulatory surgery room, dialysis center, hospice, telehealth

ORGANIZATIONAL LEVEL
Settings: Hospital service line or department, hospital QI team, multi-hospital system project, corporate office for ACO, multi-specialty clinic program, long-term care facility, EOL facility, mental health facilities

COMMUNITY/POLICY LEVEL
Settings: Coalitions, SDOH-related offices, community & state advocacy organizations, research institutions, Federal agencies, local, state, national legislature
Patients and Families Can Be Engaged At All Levels

- **BEDSIDE/PERSONAL LEVEL**
  - Contingency Teams

- **ORGANIZATIONAL LEVEL**
  - Core Team
  - Patient

- **COMMUNITY/POLICY LEVEL**
  - Coordinating Team
  - Ancillary & Support Services
  - Administration
Patients and Families Can Learn and Teach TeamSTEPPS Skills

Teachable-Learnable Skill

Teachable-Learnable Skill

Teachable-Learnable Skill

Teachable-Learnable Skill
# Patient Engagement: Examples by Level

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<td>1. Patient stories in service line meetings</td>
<td>1. Patient and community stories</td>
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<td>2. Interdisciplinary rounds</td>
<td>2. PFAs on QI/safety teams</td>
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<td>5. Patient communication boards</td>
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<td>6. Family huddles via Zoom</td>
<td>6. Policy and Procedure teams</td>
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<td>7. Telehealth visit</td>
<td>7. &quot;Warm handovers” during transitions</td>
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## TEACHABLE-LEARNABLE SKILL: COMMUNICATION
Teachable-Learnable Skill: Communication

**SBAR**
A technique for communicating critical information that requires immediate attention and action concerning a patient’s condition.

**SITUATION**
What is going on with the patient?

“Dr. Smith, this is Barb on 2 West. I am calling about your patient, Mr. Jones, in room 204. He is complaining of intense pain tonight.”

**BACKGROUND**
What is the clinical background or context?

“He’s a 63-year-old, second-day post-op hip patient who has received all of his scheduled antibiotics.”

**ASSESSMENT**
What do I think the problem is?

“While he did receive the antibiotics, he started running a fever of 102 at 11:00 pm. His incision is also quite red and I noticed some new purulent drainage. I am concerned he may have an infection.”

**RECOMMENDATION OR REQUEST**
What would I do to correct it?

“I would like you to come assess him as soon as possible. In the meantime, would you like me to draw a CBC or wound cultures?”

The Patient’s SBAR

**Situation/Symptoms** – Describe what you believe is going on.

**Background:** -- Write down 1-3 sentences describing your medical history.

**Assessment:** -- Have you ever had these issues/symptoms before? If so, what happened? If not, what do you think might be going on?

**Recommendation or Request:** -- What do you need? Include immediate needs, and needs for home or discharge, like a prescription refill.
PFE RELATIVE TO SHARING IMPORTANT OR CRITICAL INFORMATION

- Inform patients simultaneously during situations
- Help patients anticipate next steps
- Give them responsibilities, a specific task
- Check-back to be sure information is understood
- During transitions of care, provide patients with information (safety concerns, background, assessment, actions taken, priorities, responsible party, next steps)
- Communication can happen at ALL levels and settings!
# Patient Engagement: Examples by Level

## Teachable-Learnable Skill: Mutual Support

### Bedside/Personal Level
1. Bedside shift report
2. Interdisciplinary rounds
3. Patient specific safety issue
4. Shared feedback on team
5. Patient includes examples of how they seek and offer help

### Organizational Level
1. Safety rounds with PFAs
2. PFAs on QI/safety teams and pandemic planning groups
3. Patient/Family Advisory Councils
4. Patients on governance committees
5. PFAs help set dashboard metrics

### Community/Policy Level
1. Hospital/system PFAs serve on pandemic teams
2. Patient and community stories used to illustrate task assistance among groups
3. PI plans at community level are shared and co-designed
4. Community Safety Liaisons
Teachable-Learnable Skill: Mutual Support

The Patient’s CUS

I am CONCERNED

I am UNCOMFORTABLE!

I AM SCARED!

This is a SAFETY ISSUE!

I am UNCOMFORTABLE!

“STOP THE LINE”
Patient Engagement: Examples by Level

**TEACHABLE-LEARNABLE SKILL: LEADING TEAMS**

**BEDSIDE/PERSONAL LEVEL**
1. Bedside shift report initiated by patient and/or family
2. Interdisciplinary rounds
3. Patient-led goal setting and task assignment
4. Patient communication boards

**ORGANIZATIONAL LEVEL**
1. PFAs in briefs, huddles, and debriefs for safety issues
2. PFAs provide examples of “model team leadership”
3. PFAs co-lead patient safety teams
4. Patient/Family Advisory Councils lead by PFAs
5. Governance committees with PFAs

**COMMUNITY/POLICY LEVEL**
1. Hospital/system PFAs serve on community teams
2. Patient and community stories about effective teams
3. PFAs have shared decision making on community resource allocation
4. Community Safety Liaisons
TEACHABLE-LEARNABLE SKILL: LEADING TEAMS

**SHARING THE PLAN**

**BRIEF** – Short session prior to start in order to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, anticipate outcomes and likely contingencies.

**MONITORING AND MODIFYING THE PLAN**

**HUDDLE** – Ad hoc meeting to re-establish situational awareness, reinforce plans already in place and assess the need to adjust the plan.

**REVIEWING THE TEAM’S PERFORMANCE**

**DEBRIEF** – Informal information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors.

The Patient’s Plan

BRIEF family and friends after rounds (via phone, zoom, email, social media, etc.)

HUDDLE with family and friends after the patient has had a change in medical status, discharge plan, or an emotional experience requiring support, etc.

DEBRIEF with family and friends if a communication breakdown or misunderstanding occurs, especially if patient/family is not getting desired results.
TEACHABLE-LEARNABLE SKILL: LEADING TEAMS ACROSS SETTINGS
Patient Engagement: Examples by Level

TEACHABLE-LEARNABLE SKILL: SITUATION MONITORING

**BEDSIDE/PERSONAL LEVEL**
1. Bedside shift report includes ?s concerning situation from patient perspective
2. Interdisciplinary rounds cover oversights, mistakes
3. Ask patient to help monitor
4. Include patient observations in team communication boards

**ORGANIZATIONAL LEVEL**
1. PFAs scan and assess situations
2. Awareness questions imbedded in service line and system meetings
3. Patients and other team members share view of current “mental model”
4. Mistakes/oversights are discussed and addressed – with PFAs in the room

**COMMUNITY/POLICY LEVEL**
1. Community PFAs participate in mutual cross-monitoring
2. Community members serve as safety eyes
3. Community safety checklists are co-designed with PFAs
4. SDOH-related offices embed situation monitoring in meetings and ongoing reviews
Teachable-Learnable Skill: Situation Monitoring

- Progress Toward Goal (Team and Patient)
- Status of patient (as described by patient)
- Team goals (includes patient goals)
- Team tasks/actions (including patient tasks)
- Appropriateness of plan (based on patient preferences)
Objective 3: Identify the Opportunities
How is your organization engaging patients as safety champions?

A. We have patients/families serving on patient safety performance improvement teams.
B. We ask patients/families at the bedside if they have any safety concerns.
C. We have organized patient/family advisory councils that regularly review patient safety and quality performance.
D. We have patient advisors serving on key decision-making groups (i.e. Board, operations teams, etc.)
E. I am unsure how we engage patients as safety champions.
Assessment: Five Metrics for PFE
(Partnership for Patients/CMS)

**Point of Care**
- Preadmission Planning Checklist (PFE Metric 1)
- Shift Change Huddles OR Bedside Reporting (PFE Metric 2)

**Policy & Protocol**
- Designated PFE Leader (PFE Metric 3)
- PFAC or Representatives on Hospital Committee (PFE Metric 4)

**Governance**
- Patient Representative(s) on Board of Directors (PFE Metric 5)
Assessment: Organizational Level

- **Leadership**: Patient and family inclusions in policy, procedure, programs, Governing Board activities
- **Advisors**: Serve on hospital committees, quality and safety rounds, councils
- **QI**: Patient voice informs strategic and operational goals, patients are members of task forces, safety meetings, quality and safety education
- **Personnel**: Job descriptions include expectations for collaboration with patients, patients participate on interview teams, search committees, new employee orientation

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<thead>
<tr>
<th>Leadership / Operations</th>
<th>Clear statement of commitment to PFCC and PF partnerships</th>
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<td>Explicit expectation, accountability, measurement of PFCC</td>
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<td>PF inclusion in policy, procedure, program, guideline development, Governing Board activities</td>
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<th>Mission, Vision, Values</th>
<th>PFCC included in mission, vision, and/or core values</th>
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<td>PF-friendly Patient Bill of Rights and Responsibilities</td>
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<th>Advisors</th>
<th>PF serve on hospital committees</th>
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<td></td>
<td>PF participate in quality and safety rounds</td>
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<td>Patient and family advisory councils</td>
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<th>Quality Improvement</th>
<th>PF voice informs strategic/operational aims/goals</th>
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<td>PF active participants on task forces, QI teams</td>
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<td>PF interviewed as part of walk-rounds</td>
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<td>PF participate in quality, safety, and risk</td>
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Assessment: Checklist of Attitudes

Do I believe the patient and family bring unique perspectives and expertise to the interactions?

Do I consistently let colleagues know that I value the insights of patients and families?

Do I believe that patients and family members can look beyond their own experiences and issues?

Do I believe their opinions and perspectives are equally valid in planning and decision-making at the program and policy level?

https://www.ipfcc.org/resources/Checklist_for_Attitudes.pdf
Engage Patients and Families

1. Establish clear goals
2. Promote a culture of teamwork
3. Define support needed to sustain efforts
4. Provide ongoing coaching and mentoring
Patient Engagement Must Be a Priority
AHA Annual Survey (2018 data)

Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?

All Hospitals (N = 6,218)
• 31.4% Yes (1,952)
• 28.2% No (1,756)
• 40.4% did not respond (2,510)

AHA Members (N = 4,247)
• 39.6% Yes (1,682)
• 28.5% No (1,212)
• 31.9% did not respond (1,353)
Define the why, what, how, and when
Culture of Teamwork: Patients, Families, Community Members on Teams

- Patient Stories
- Patient Safety Liaisons
- Quality Teams
- Staff Education
- Patient Education
What Support is Needed to Sustain the Commitment Over Time?
Coaching and Mentoring
SET GOAL

MAKE PLAN

GET TO WORK

STICK TO IT

REACH GOAL

FACE SMILEY
Make A Commitment

In the Chat Box write:

What is **ONE THING** you will do to ensure patients are more engaged in your teamwork after you leave today’s presentation?
Engaging Patients: Sprints and Marathons!
Key Takeaways

• Patients, families, and communities are untapped resources in an organization’s patient safety initiatives
• Patients can be safety champions and change leaders across the care continuum
• There are numerous opportunities to engage patients and families in patient safety initiatives
• TeamSTEPPS tools can be adapted to engage patients as change agents
• All team members need support to embrace the patient and their family as safety partners
Selected Websites and Resources


- Institute for Patient- and Family-Centered Care (IPFCC) www.ipfcc.org

- Consumers Advancing Patient Safety (CAPS) www.patientsafety.org

- National Patient Safety Foundation (NPSF) www.npsf.org

Thank you for joining today’s webinar.

Join us for an office hour on Wednesday, December 16 from 1:00 to 2:00 pm CT. Register now on Mighty Network!

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Questions? Stay in Touch!

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