



# Can Patient Partnerships Make Healthcare Safer?

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## Overview of Learning

- Safety advantages of engaging patients (and family / carers) as active members of the healthcare team
- Partnering techniques that reduce the risk of adverse events
- Tools for creating effective safety collaborations that enhance consumer satisfaction



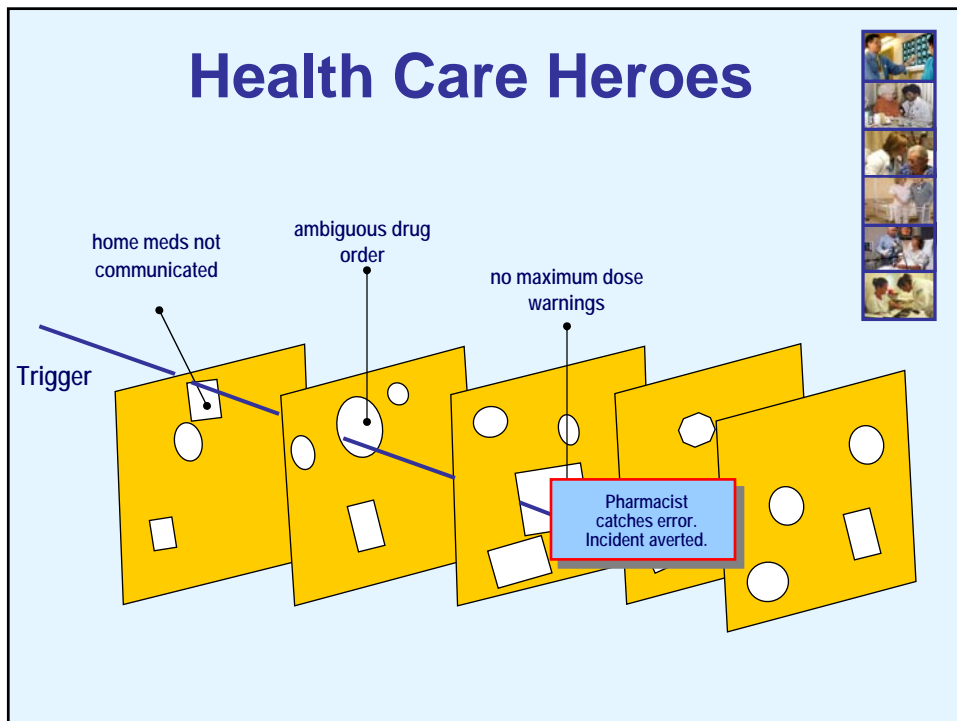
## If Not a Crisis, Certainly a Loss of Public Confidence!



## Initial Patient Safety Improvements

- Strengthen traditional methods to create safer systems and practices
  - New policies/procedures
  - Process improvement (RCA / FMEA)
  - Gather and analyze incident data
  - Physician/staff training





## Consumers Can Also Be Health Care Heroes



Patients are the only constant in the continuum of care



## Another Pair of Eyes in the System

- Patients / family / carers can help prevent some mishaps if *actively* invited and given *consumer-friendly* tools
  - Environmental safety
  - Clinical safety



## Why This is Important

- We are missing opportunities to add additional safeguards if we fail to include patients and their families in our efforts to improve safety.
- Until the patient participates in their care, we reinforce the separatist care-giver vs. care-recipient notion of healthcare.
- Patients want a safe health care experience and want to help us make sure that happens.



## Studies of Consumer Involvement in Safety

- Rigorous research and debate is needed to determine the appropriate role for patients in efforts to improve safety.
- Advice given to patients must be periodically examined and updated with consumer input.
- “Rather than relying on patients to work around system deficiencies,” the authors say, “systems should be designed to enable people to contribute appropriately by default.”



Entwistle VA, Mello MM, Brennan TA. Advising Patient About Patient Safety: Current Initiatives Risk Shifting Responsibility. *Journal on Quality and Patient Safety* (Sept. 2005), 31(9) Online source: <http://www.cmwf.org/publications/>

### 2004 Survey of 195 Staff at University of Oregon (clerical, food service, maintenance)

Item	Perceived Effectiveness	Likelihood of Doing
Making sure all of your doctors know about every prescription medication you are taking	5.26	4.25
Confirming you are getting the right medication and dose	5.22	3.00
Bringing in someone who can be your advocate to the hospital	5.18	4.79
Finding out the results of any test at the hospital if you are not told	5.13	5.47
Choosing a hospital based on a report that compares medical errors in different hospitals	4.60	3.23
Having your surgeon mark where the surgery will be	4.53	3.11
Asking health care workers who come in contact with you if they have washed their hands	3.54	1.73

Effectiveness: 0 = not at all effective, 6 = very effective  
Likelihood of doing: 0 = not at all likely, 6 = very likely

Hibbard, JH et al. Can patients be part of the solution? Views on their role in preventing medical errors. *Medical Care Research*, Vol. 62, No. 5 (Oct. 2005) 601-616

### 2005 Interview of Hospitalized Patients

- 91% agreed that patients should help prevent errors
- 98% agreed that hospitals should educate patients about error prevention

Error Prevention Behavior	N	% Very Comfortable	% Who Took Action
Ask nurse purpose of medication	948	91.3	75.2
Ask questions about medical care	985	88.8	85.1
Ask nurse to confirm patient's identity	900	84.2	37.8
Have family or friend watch for errors	966	76.0	38.6
Tell medical staff that error occurred	112	78.4	79.7
Helping health care professionals mark surgical location	518	71.5	17.3
Ask medical personnel whether they washed their hands	924	45.5	4.6

Waterman AD, Gallagher TH, Garbutt J et al. Brief report: Hospitalized patients' attitudes about and participation in error prevention. *Journal of General Internal Medicine* (Apr. 2006) 21, 367-70

## Does Consumer Involvement Reduce Harmful Incidents?

- At this time, the relationship is mostly anecdotal



While visiting her hospitalized mother, the daughter noticed her mother had a certain “look” that usually occurred when her blood sugar was low. There were no changes in her mother’s clinical condition and she had been stable for several days on the same insulin dose. Fortunately, the nurse listened to the daughter’s concerns and did a glucometer check and found the mother’s blood sugar was only 1.9 mmol/L (normal blood sugar being 4 to 6 mmol/L). She was given IV concentrated dextrose to treat the low blood sugar; a potentially harmful condition that was not readily apparent to the caregivers.

## Does Consumer Involvement Improve Satisfaction?

- Hospital units that were more patient centered were associated with higher patient satisfaction

Bechel DL, Myers WA, Smith DG. Does Patient-Centered Care Pay Off? *The Joint Commission Journal on Quality Improvement* 2000; 26(7): 400-409



- Teamwork culture found to be positively associated with inpatient satisfaction

Meterko M, Mohr DC, Young GJ. Teamwork culture and patient satisfaction in hospitals. *Medical Care* 2004; 42(5): 492-498.



## What We Know Today

- Patients/families are increasingly interested in being involved in preventing errors



- **Ostrich:** “It won’t happen to me. It’s not my job to prevent medical mistakes.”
- **Passive:** Wants to know how to prevent mishaps, but won’t act unless caregivers are supportive.
- **Assertive:** Deliberately seeks out information on how to prevent mistakes and assumes a proactive role.

## What We Know Today

- Barriers can inhibit patient / family / carer involvement
  - Fear
    - Care may be compromised or they may be labeled a “problem”
  - Not “Invited”
    - Speaking up not *actively* encouraged by caregivers
  - Speak-up expectations too overwhelming
    - Consumers inundated with information





## All Consumers Are Not Created Equal

- Chronic care vs. episodic care
- Differences in attitudes and behaviors
- Cultural and age variations
- Health literacy



## Creating Effective Patient / Family Partnerships

- An organization-wide commitment with top leadership support is needed to overcome barriers
  - Physicians and staff dislike being challenged or not trusted
  - Physicians and staff fear that involving patients will take more time than is available
  - Physicians and staff often don't recognize the safety value of involving patients/families





## Creating Effective Patient / Family Partnerships



- Produce consumer-friendly messages
  - Use the phrase “preventable mistakes” instead of medical errors
  - “Medical errors” more commonly understood than “patient safety”
  - Taglines have greater impact than statistics, e.g., “Medical errors can be prevented.”
  - Shorter, simpler and straightforward messages are best

Summarized from 16 focus groups conducted Apr-Sep. 2001 by the Foundation for Accountability and KRC Research & Consulting for the Leapfrog Group. Complete report available online at: <http://www.leapfroggroup.org>

*“It’s OK to ask”*  
...at Legacy Health System

**We have a saying at Legacy Health System — “It’s OK to ask.”**

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*That means “It’s OK to ask” questions about your health and your healthcare. “It’s OK to ask” about your medications. “It’s OK to ask” your nurse and doctor about treatments. “It’s OK to ask” for help. “It’s OK to ask” about the results of tests.*

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*“It’s OK to ask” for practically anything.*

+

*It’s not only OK, we encourage it. We want you to become a part of the medical team. And it’s important for your health. National studies show that patients who take part in decisions about their healthcare are more likely to have better outcomes. Patients also reduce medical errors by taking part in their care.*

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*“It’s OK” to become involved in your care or that of your family member. “It’s OK” to join the team. “It’s OK” to know what’s happening with your care.*

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**“It’s OK to ask.”**

**We encourage you to ask**

*Here are some questions you may consider asking your caregivers:*

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Have you washed your hands?

Will you wear gloves during my exam?

Can you check my wristband before giving me a medication or administering a medical procedure?

Will this medication cause allergies or adverse reactions?

Can you verify my prescription?

How long should I take my medications?

Do I need to take them with food or water?

What are the side effects?

Is the medicine safe if taken with other medicines or over-the-counter drugs?

Can I have help to the bathroom?

How will the test or treatment ordered help me?

What are the results of my test?

Can you tell me what signs to look for while monitoring my care at home?

How do I get necessary home healthcare equipment and supplies?

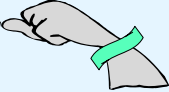
Can my caregivers have copies of my records?


Legacy Health System, Portland, OR  
<http://www.legacyhealth.org/documents/Misc/ItsOK.pdf>


## Patient Safety Poster

(also available in Spanish)

### Be Involved in Your Care

**Make sure the nurse checks your armband before giving you your medicine.** 

 **Ask the nurse about medication that is unfamiliar to you BEFORE you take it.**

**Make sure the staff and physician washes their hands before / after providing care to you** 

OSF St. Joseph Medical Center, Bloomington, IL

## Creating Effective Patient / Family Partnerships

- *Actively* encourage patient / family involvement

Sample Script:

*Your safety is important to us. It is just as important for you to know what questions to ask about your care. Let's work together on this. Now let's review some of the safety information. Tell me about any concerns you may have regarding your care.*

**Please  
ask**



## Creating Effective Patient / Family Partnerships

- Seek out opportunities to expand patient / family partnerships



**Condition H**

Shadyside Hospital is building the hospital of the future with the help of patients and families we care for. We believe in teamwork, and ask that you be a part of our team when visiting your loved ones.

**Dial # 3-3131**  
From Any Hospital Telephone

In July 2005 UPMC Shadyside Hospital, an affiliate of the University of Pittsburgh Medical Center, implemented a response team that could be initiated by patients and families

Greenhouse PK, Kuzminsky B, Martin SC, Merryman T. Calling a Condition H(elp) *American Journal of Nursing* 2006; 106(11): 63-66



We believe that teamwork is the best way to give safe care to our patients. As NorthEast Medical Center grows to be a hospital of the future, we ask that our patients, families, and visitors become part of the team. **Code Care** is all about teamwork and saving lives.

**Reasons to call Code Care:**

- You feel that a serious change in the patient's health is not getting the attention you think it needs.
- There is confusion or conflict with a caregiver over what needs to be done for the patient

**Calling Code Care:**

If you ever feel you are not getting the care you or your loved one need during an emergency, call **Code Care** by dialing **8888**. Use any phone in the hospital. The hospital operator will ask you:

- the patient's location,
- the patient's name, and
- the reason for the call.

Within minutes, a small team of caregivers will arrive to help you.

**We hope that you never need to call a Code Care. But, we do value your help on our team as we strive to provide the highest quality and safest care possible.**

Spath PL. Empowering Patients in Emergencies. *H&HN Online* February 20, 2007. <http://www.hospitalconnect.com/hhnmag/jsp/hhnonline.jsp>

## When Patients / Families Do Speak Up -- Respond Supportively

*(Sigh) Trust me Mr. Stewart. These are your pills. I checked them myself.*



*Those pills look different than what I usually take for my heart. Are you sure you are not giving me someone else's medicine?*

## Caregivers May Need New Skills

- Train caregivers how to interact with patients and families
  - Active listening skills
  - Scripts

*Thank you for telling me. I am sorry this happened. I understand why you are upset. This is what I am going to do about it. I will get back to you in a little while and make sure everything has been resolved.*



## Engaging Patients Must Be a Mindset, not a Program

- Campaigns have limited time-value
- A culture of patient safety and patient / family involvement must be supported and cultivated
  - Leadership
  - Strategic initiative
  - Accountability



## Patient Partnership Resources

- American Hospital Association, Institute for Family-Centered Care. *Strategies for Leadership: Patient- and Family-Centered Care* (2004) Chicago: American Hospital Association (<http://www.aha.org/aha/issues/Quality-and-Patient-Safety/patientcentered.html>)
- *Improving Communication -- Improving Care* (2006) Chicago: American Medical Association
- McGreevey M. *Patients as Partners: How to Involve Patients and Families in Their Own Care* (2006) Oakbrook Terrace, IL; Joint Commission Resources
- Spath PL. Can You Hear Me Now? *Hospitals & Health Networks*, Dec. 2003 ([www.hospitalconnect.com/hhnmag/](http://www.hospitalconnect.com/hhnmag/))
- Spath PL. *Partnering with Patients to Reduce Medical Errors* (2004) Chicago: American Hospital Association





## One Day Workshop

*Creating Safety Partnerships with Patients: A Leadership Guide*

May 17, 2007

Fall 2007 date to be announced



## Be Safe

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