Patient's View Project Proposal

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Learning Goals:

Goal 1: Develop foundational knowledge about Continuous Quality Improvement & Patient Safety within the Healthcare System: attend 4 hour orientation session to the Patient's View Project

Goal 2: Demonstrate ability to engage patients and families on inpatient units at BCCH for the purpose of soliciting feedback related to quality of care and patient safety.

Goal 3: Demonstrate ability to analyze data, identify trends and formulate quality improvement recommendations.

Project Tasks:

- Actively participate in and facilitate discussions with patients and families about their healthcare experience for improving patient safety.
- Use computer applications to collect and report safety concerns and patient safety events.
- Participate in Patient's View steering committee meetings for the purpose of fully integrating the Patient's View project into the daily operations at BCCH.

Project outcomes that students will be responsible:

- Collect and report data into electronic database.
- Create a presentation for Patient's View steering committee.
- Assist in the revision of the Patient's View Orientation.

Required Skills:

- Strong communication skills and abilities to consult and confer with others and gather information; experience connecting with families for the purpose of data collection an asset.
- Consistently demonstrates honesty, integrity & respect in all interpersonal relationships.
- Demonstrates the ability to assume personal & professional responsibility and accountability for learning, practice and well being.

Additional Information:

Please see attachment.

Establishing a Family-initiated Patient Safety Reporting Program at BC Children's Hospital: The "Patient's View"

The Problem:

Over the past decade, studies in Canada and other countries have estimated that adverse events causing harm affect approximately 10% of patients admitted to hospitals, with nearly half of these events being possibly preventable.[1] Recent research revealed more than 9% of children in hospitals in Canada experience an adverse event and the risk of having an adverse event is nearly 3-fold higher in academic pediatric centers than in community hospitals.[2] To reduce the incidence of adverse events, leaders must have reliable information about the events, learn from this information and apply the learning to make our healthcare system safer. Many opportunities for improvement are lost because healthcare provider-initiated reports significantly under-represent true adverse event rates. Research has shown that reports of events detected by patients and families bring a unique perspective to patient safety.

The Method

In 2008/09, Ansermino and colleagues developed, tested and evaluated a web-based tool called the *Bedside Observer*.[3] Using a version of the BC Patient Safety & Learning System (BC PSLS), they elicited reports of safety concerns and events from families of children admitted to one unit at BC Children's Hospital. The research validated the tool and process and demonstrated that families were capable of reliably identifying and reporting legitimate adverse events.

To translate this powerful research into action, Denise Hudson from the provincial BC PSLS team and an enthusiastic task force from BC Children's launched a pilot project on an inpatient unit in August 2012. With strong support from senior leadership, an innovative face-to-face patient and family engagement model was trialed. Eight volunteers with hopes for future healthcare careers were selected from an existing pool, orientated to the new role and deployed with a laptop computer to seek the "Patient's View", the name for the project chosen with input from patients and families, clinical staff and quality and safety leaders. Staff on the pilot unit was engaged through safety rounds, posters and emails.

Standard work started with volunteers obtaining a list from the Charge Nurse identifying families whose child was slated for discharge within 48 hours and who were considered by the Charge Nurse to be appropriate for interview. The volunteer then approached and engaged these families at the bedside, inviting them to share any safety concerns using the laptop and a tested, validated web-based tool. The quality leader reviewed the reports and staff and leaders used the feedback for action planning and quality improvement.

Was the pilot project a success?

A variety of indicators were measured:

1. Process measure: Volunteer success

   The volunteers reported a positive experience where they felt supported, valued and they had contributed to safe care at BCCH. The volunteers were asked by electronic survey:

   - How would you rate your volunteer experience with Patient's View?
     50% - excellent 50% - Good 0 - Fair 0 – Poor
   - Did you receive appropriate training and support so that you could perform your role effectively?
     100% answered yes

- Did you feel your work is making a difference for Patient Safety?
  50% - always 50% - sometimes 0% - Never
- Would you recommend the Patient's View experience to others who are looking or volunteer opportunities?
  100% answered yes

One volunteer stated:

> *"I think it is a great way to interact with the families/patients that is different from other volunteer roles because you have a purpose and topic of conversation. It gives great insight into their experience and has made me more empathetic to the patients and families' situations at BC Children's hospital. For those volunteers looking to pursue a career in any sort of healthcare I feel this is a valuable experience."*

2. Process measure: Family participation rate

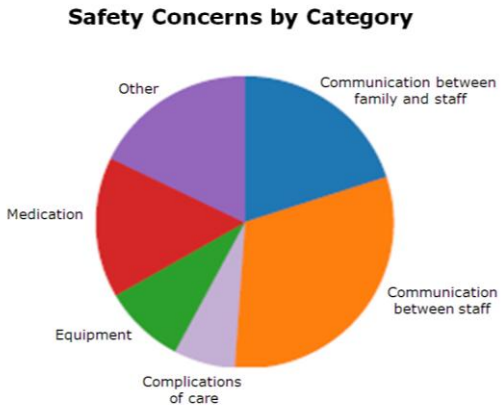
   September 10 to November 19, 2012

   - 65% of shifts had a volunteer assigned
   - 420 discharges (total)
   - 109 on week-ends when there was not coverage
   - 311 on weekdays (covered by volunteers)
   - 100/311 families identified by Charge Nurse as appropriate
   - 3 families declined participation
   - 46 sleeping, out of room, bad timing, etc.
   - 51 participated
   - 51% of eligible families participated=12% of total discharges

3. Process measure: Validity of reports

   76 safety concerns were reported and 70/76 = 92% were assessed by 2 independent patient safety experts as valid safety concerns (this was the same method used during the research study to validate reports).

4. Process measure: What did patients and families tell us?



Family reports were rich and meaningful. The mother of a child from a small rural community described a breach of confidentiality when clinical staff discussed her child's past medical history at the bedside in front of her extended family - information she wanted kept private. She was devastated. A father shared his feelings of anxiety when two physicians - within five minutes of each other - told him conflicting plans for his acutely ill child. One said the child needed surgery as soon as possible to prevent a life-threatening complication; the

other recommended overnight observation with a decision about surgery in the morning. Dad spent a sleepless night watching over his child.

Although our focus was on adverse events and safety concerns, we believe "There is more to safety than avoiding the things that go wrong or reducing the number of adverse events…it is necessary to focus on what can go right".[4] We know that families notice when things go wrong, but do they notice when things go well? To find out, families were asked to describe anything they noticed staff or the hospital doing to help promote safe care.

Answering this question, one mother described a surgical problem that occurred shortly after her baby's birth, requiring many corrective procedures. Anxious on admission to the surgical ward, the family found great relief in the role of Safety, Personal Care, Admits/Discharge and Workload (SPAW) nurse, a fairly new and innovative role on the unit. The mother described the SPAW nurse demonstrating complex care for her baby to nurses at change of shift, including wound care and correct positioning. The family could finally relax. The SPAW nurse is an excellent example of a team working to improve everyday performance, build resilience and provide safer care. "Proactive safety management must focus on how everyday performance usually succeeds rather than on why it occasionally fails, and actively try to improve the former rather than simply preventing the latter".[5] Families are a wealth of information about where things are working well, not just where they're not, and we can apply learning from both to drive improvement.

5. Process measure: Family satisfaction with process of being asked about safety concerns:

   A volunteer reported:

   "One mother actually thanked me after doing the survey because she found it very therapeutic. I have never had a parent turn me down or not be appreciative for what we do."

   And from the families:

   "This conversation is one example of the unbelievable level of engagement with families within BC Children's hospital."

   "I am a business man and have been doing surveys with customers for years. It is excellent you are initiating this at Children's; I believe it will make care safer. Thank you."

6. Outcome measure: Quality improvement initiatives informed by feedback from Patient's View.

   - In progress: Medication reconciliation and a comprehensive family-centered approach to transfer of care
   - Update to MRSA screening policy
   - A standardized process for ED staff obtaining urine prior to assessment by a physician to improve flow and decrease wait times.
   - Standard approach to post operative pain control and teaching following tonsillectomy/adenoidectomy
   - Process for calling families back to the bedside for procedures and rounds with health care professionals.
   - Communication opportunities such as Coaching Out of the Box for front line staff and Health Compass e-learning

7. Balancing measures:

   - Number of spurious reports = 0
   - Number of reports not related to patient safety = 6
     - All 6 reports were complaints related to food quality and room cleanliness
   - Ward and risk management resources needed for individual follow-up on family reports: Minimal
     - 51 reports x 5 minutes review = 4.25 hours during the 10 week Pilot
   - Number of volunteers reporting they cannot meet the expectations of the role = 0
   - Number of complaints to the Patient Care Quality Office = 0

Key Findings:

- Families are happy to be invited to give feedback on patient safety and highly motivated to report
- Trained volunteers are an excellent resource to engage families to report patient safety events
- Patient's View volunteer is a satisfying role for students interested in a future in healthcare
- Soliciting reports within 48 hours of discharge has a high degree of acceptance
- A simple web-based reporter form and laptop provides a rapid and reliable method for families to report safety events, although volunteers suggest a tablet device would be more convenient
- Face-to-face engagement with families is important to facilitate family reporting.
- Patients and families are able to report legitimate safety concerns
- Feedback from patients view can inform and validate quality improvement work

Conclusion:

The pilot project was successful based on all indicators. The volunteer model worked well and was particularly effective at engaging families and providing them with an outlet to share their stories. A side benefit for volunteers was the positive impact their participation had on them as individuals and the long-term benefits that may result as they pursue future careers in healthcare. Families appreciated being asked about their experiences and were able to provide accurate and legitimate reports of adverse events and safety concerns. The information gleaned from the reports was useful to staff and leaders in the area and helped inform safety and quality improvement initiatives. The additional staff time required to review submitted reports was minimal. In summary, this was a very successful undertaking with significant positive outcomes for families, volunteers and the organization and required only a small investment in time and effort. We hope to see the project expand further as we think this approach offers great potential for engagement, learning and improvement.

References:

1. De Fries EN, Ramrattan MA, Smorenburg SM, et al. The incidence and nature of in-hospital adverse events: a systematic review. Quality & Safety in Health Care. 2008 June; 17(3): 216-223

2. Matlow AG, Baker R, et al. Adverse Events Among Children in Canadian Hopstials: The Canadian Paediatric Adverse Events Study. CMAJ September 18, 2012, 184 (13)

3. Daniels JP, Hunc K, Cochrane DD, et al. Identification by families of pediatric adverse events and near misses overlooked by health care providers. CMAJ January 10, 2012, 184 (1)

4. Hollnagel E. How Resilient Is Your Organization? Sustainable Transformation: Building a Resilient Organization, Toronto: Canada. April, 2010

5. Hollnagel E. Proactive approaches to safety management. The Health Foundation: Inspiring Improvement. May, 2012