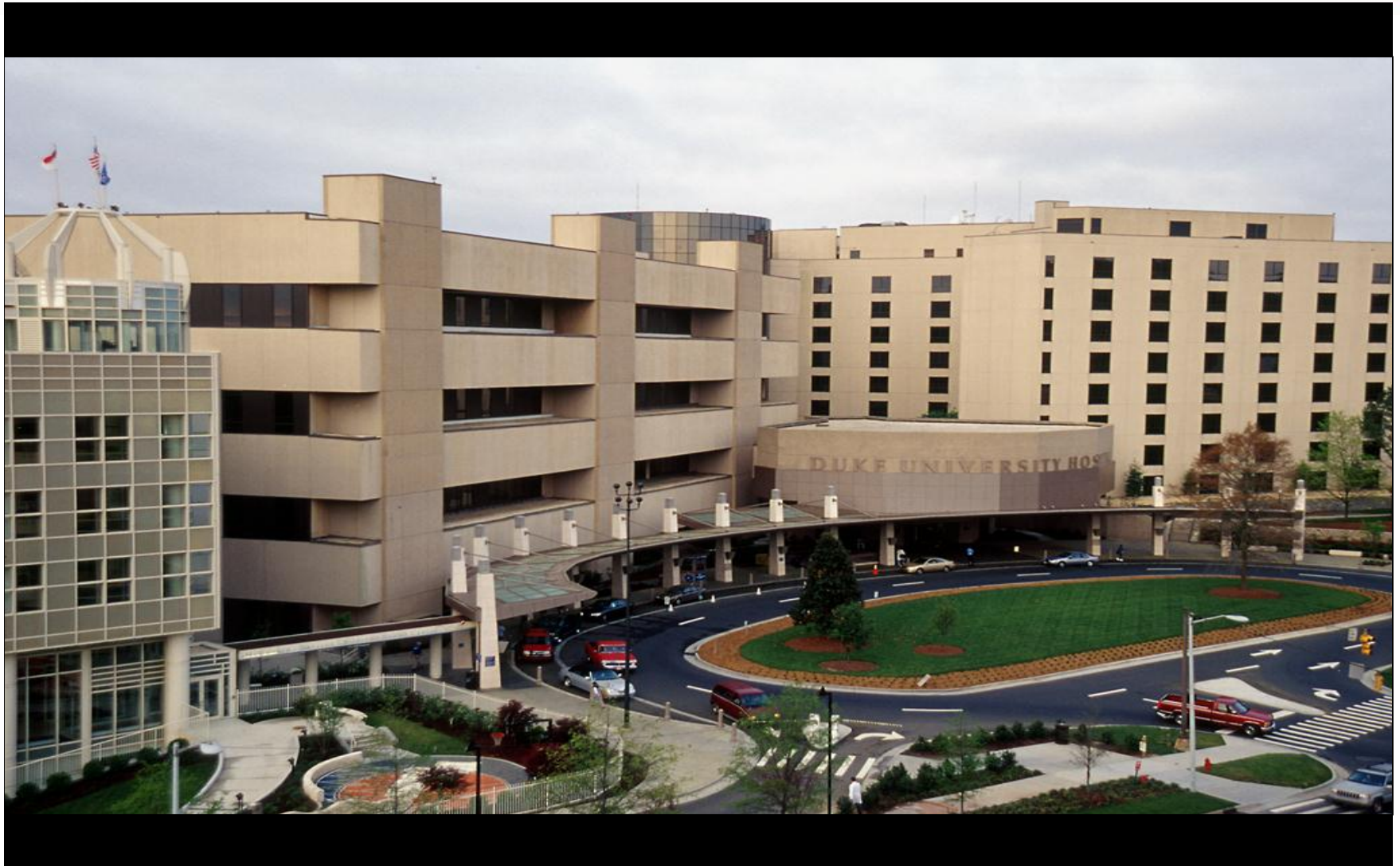




Duke University Hospital





Jesica Santillan

February, 2003

- 17 yr old young woman with complex congenital heart disease
- Followed in clinic with progressive disease; transplant candidate
- Donor identified
- Transplant completed; call from lab - wrong blood type
- Shattered family
- Devastated nurses, physicians and entire team





Framework for Safe and Reliable Care at Duke Medicine

- Patient safety leaders at all levels of organization
 - DUHS Board of Directors, Senior leaders, Departments, CSU, Unit level
- Develop robust risk identification and mitigation strategies
- Address systems issues (fix defects)
 - Highly complex system: standardize and simplify
 - IT systems to enhance safety
- Transform our culture
 - From individual experts to expert teams
 - From punitive culture to culture of accountability
 - From “patient centric” to active partnering, listening, and engaging with patients and families



TeamSTEPPSTM

- Implementation of *TeamSTEPPSTM* at Duke
 - Component of comprehensive PS program
 - Focus on safe systems, safe culture, safe people
- *TeamSTEPPSTM* for Patients
 - Patients as trainers
 - Tools for patients and families



2005: *TeamSTEPPS™* Contextual Model and Curriculum

- Evidence-based curriculum
- Core content modules
 - Flexible content delivery
 - Train-the-trainer model
- Process improvement approach
 - Assessment and action plan
 - Training and implementation
 - Evaluation and feedback
 - Sustaining
- Coaching module, observations
- “Tool box”





Operational Changes, Improvements in Outcomes

- Briefings and debriefings implemented; SBAR communication for nursing report, telephone communication
- Decrease in infection rates (3% to <1%)
- Patient Satisfaction score exceeded target
- Work Culture survey score increased by 16%



The Role of Patients in Patient Safety

- Most patient safety strategies are focused on error prevention and mitigation from a healthcare provider and system perspective
- Some organizations have begun to highlight role that patients can play in improving safety and quality
 - being knowledgeable about treatment plans
 - asking for clarification when they don't understand
- Understanding role of patients in patient safety, as well as barriers to engaging patients, can help reduce adverse events and improve quality of care
- *Fear of retribution, lack of tools, not feeling invited to be a partner, not feeling competent*



What is the Role of Patients?

- Challenge ourselves to think differently about “partnering with patients”
- Encourage patients to take an active role
- Facilitate opportunities for patients to “speak up” and share their ideas about reducing harm
- Patients are helping us with this at Duke





What Patients are Facing

- Between 44,000 and 98,000 people die every year due to medication error
- Distractions were identified as a contributing factor in 46% of medical error
- Cognitive error, like anchoring, is the foundation of most ED diagnostic errors
- 60% of sentinel events were caused by poor staff communication--"bedside hand off"



Having patients be a part of the care team is a popular ideal but one that needs more thought and concrete strategies



The Bad News:

The recent Medicare data has confirmed disappointing results of the national efforts to improve patient safety over the past decade.

We have fallen short of the national goal established by The Institute of Medicine IOM report, published in 1999....



The Potential Good News:

One reason for this is the fact that improvement efforts have focused on only half of the team

Now, it's time to take patient-centered care and patient safety to a new level



What if patients and families were trained
like passengers?

Could cause irritation (like at the airport)
but it would be expected and routine
safety measures



Aviation and Health Care

Aviation Model and Partnership

In Aviation:

Professionals do a cockpit check

In Medicine:

Professionals do call outs in trauma resuscitations

In Aviation:

Passengers go through security (computer, liquids, shoes, metal)

In Medicine:

Patients can be responsible for med checks, participating in bedside hand-offs and routine wrist band checks

In Aviation:

Passengers are told repeatedly about flight risks and safety measures

In Medicine:

Patients must be educated about possible outcomes before a crisis and given tools for planning and safety



Empowerment through Involvement

- Educating patients/families on the need
- Setting expectations of understanding and competency
- Giving strategies and “jobs”



Permission + Tools

=

Safety

Empowerment

- SBAR
- CUS(S)
- Patient (Safety) “Call Out”



Partnering through Preparation

Symptoms

Background (relevant)

Assessment

Request (immediate)



Partnering for Safety

Concerned

Uncomfortable

Scared

Safety



Partnering for Patient-Centered Care

Help us Find our Voice by
Finding our Call Out

“Whoa”

“Time Out”

“I’m Confused”



Assess Patient/Family Participation Skills

- Expert Patient and Family
Trained in SBAR for more concise and effective conversations at clinic, in the hospital or the ER
- Eager Patient and Family
Track own data and medicines
- One Step at a Time Patient and Family
One simple “job” at a time



Giving Your Patient a “Job”

Remember our lack of purpose and worth?

Help us by helping you! Give us a job to do to be proactive and safeguard our own health.

Example: Next Slide



Ed Johnson from TeamSTEPPS

- **Setting: Clinic**

Ed Johnson, a 41-year-old patient with a history of hypertension, is seen in the Cardiology Clinic for a follow-up after his recent admission to rule out a myocardial infarction. His vital signs are normal except for a BP of 170/110. An EKG shows NSR without evidence of ischemic changes. He states that he has been having episodic chest pain since his release, so the physician decides to repeat his cardiac enzymes. His CPK is 201, and a Troponin I level is pending.

- Mr. Johnson's pain resolves, and he insists on going home. The Troponin I level is still pending when Mr. Johnson is discharged with instructions to call the office the next day if he is still having problems. Shortly after Mr. Johnson is discharged, the Troponin I level of 0.22 (normal <0.03), indicating myocardial ischemia, is called in to the nurse in the clinic. The nurse notifies the physician of the result. No attempt is made to contact Mr. Johnson. Later, he is found unresponsive and having difficulty breathing. His friend calls 911, and when the ambulance crew arrives, they find him apneic and they cannot detect a pulse.

- **Instructor Comments**

- In this scenario, the nurse and the physician fail to advocate for the patient. A check-back or existing process is lacking to ensure the physician and nurse both understand roles and action items, and the patient is not contacted. This failure to communicate as soon as possible may have contributed to his demise.



Consider creating a Patient Advocacy Council

- Hospital/Health system leader and patient advocate co-chairs
- Council reports to Chancellor (Senior Leader)
- Formal governance document defining criteria for participation, leadership terms, policies and procedures
- Monthly meetings with agenda and minutes
 - Task force and sub-committee for focused initiatives
- Review metrics (eg, patient satisfaction) and follow progress
- Provide meals, parking passes, annual appreciation event

Thank You!

