Partnering with Patients and Families to Improve Quality and Patient Safety

Tanya Lord PhD, MPH
Director, Patient and Family Engagement
tlord@healthynh.com

Strategically Create a PFE Culture

PFE is not a Single Strategy!
Making the PFE/Quality Improvement Connection

We are underutilizing the expertise of patients and families

Make the Connection Worksheet

• As we go through different strategies identify quality improvement or patient safety goals each strategy would fit.

Make the Connection: PFE Strategies and Quality

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Direct Care

• If individuals feel their beliefs, desires, and culture are considered in their care, they are more likely to follow their care plan.

• If individuals are able to communicate effectively with their providers and have a prominent role in making health care decisions, they will receive better care, can more effectively manage their health, and may receive appropriate preventive care while relying less on emergency or urgent care.


Tools for improving quality and patient safety (bedside)

• Discharge Planning
• Bedside Shift Report
• Shared Decision Making
• Teach Back

Discharge planning
Pre-Admission Checklist For Scheduled Admissions

Benefits for patients/caregivers:
• Reduced stress/anxiety:
  • Learn what to expect
  • Understand risks associated with procedure
• Special needs identified in advance
• Extra time to formulate questions

Check List Inclusions

• A physical checklist that encourage conversations with patients it can include:
  • What patients should expect
  • Patient concerns and preferences care
  • Potential safety issues (pre-admission medicines, history of infections, etc.)
• Relevant home issues
  • Support Needs
  • Transportation
  • Care Coordination
Document The Conversation

- Patient preference, concerns, and expectations expressed by patients/family members
- Share with the entire hospital care team for ongoing communication
- Patients and families should retain a copy of the checklist.

What Message are you Sending?

Write it down - Join your team!

What did the doctor tell you?
What medications do I need to take?
How do I take my medication?


Bedside Shift Report
Bedside Shift Report

- Nursing staff conducts shift change reports at the patient's bedside
- Patient can identify a family member or close friend to participate
- Report should take about 5 minutes per patient
- Purpose:
  - To engage the patient and family in hospital care
  - To share accurate and useful information between nurses, patients, and families

Benefits

- Bedside shift report can improve:
  - Patient safety and quality
  - Improved communication
  - Decrease in hospital-acquired complications
  - Patient experiences of care
  - Time management and accountability between nurses
  - Decrease in time needed for shift report
  - Decrease in overshift time
  - Patients are able to supply missing information or correct erroneous information

More Benefits

- Builds trust in the care process
  - Shows the patient how much nurses know and do for them
  - Shows teamwork among the nursing staff, reassuring the patient that everyone knows what is going on with them
- Encourages patient and family engagement
  - Gives the patient and family an opportunity to ask questions and correct any inaccuracies in handoff
  - Informs the patient and family members about the patient’s care throughout the stay and helps with the transition to home

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Include the Patient and Family

- Active participation as much as they desire
- Allow patients to opt out
- Part of the entire discussion not just selected parts of it
- The patient and/or family member is able to:
  - hear
  - question
  - correct or confirm
  - learn more about the next steps in their care

Talk in front of a patient???

Shared Decision Making

Shared relationship between patient and provider most important to advance healthy behaviors

Shared Decision Making

Recognize Opportunity
- A healthcare decision needs to be made

Use Decision Aids
- Tools to educate patient and family on options

Have a Conversation
- Discuss options
- Assess patient and family understanding

Patient receives care
- That has been agreed upon by everyone

Teach Back
- Method to confirm patient’s understanding
- Tell me, in your own words....
  - why you need this medication
  - how you would take this medication

Teach Back not a test of patient’s knowledge Is a test of how well we explain something


Invite Patients to Engage
- Patients and families won’t engage if they believe that you don’t want them to—it is simply too risky for them
- Your job is to make it safe for them to be involved, not just as patients but as partners in their care
Patient Engagement Organization Level

Quality Improvement Cycle

- Spread
- Innovation
- Implementation
- Pilot

Innovation

- Identify a HAC or other focus
- Include PFAs as team members to brainstorm ideas
- Patient Innovation Committees: Patients and staff who work together to brainstorm a specific HAC improvement
- Be willing to try something different
- Allow patient and families to innovate and explore proposed ideas
Pilot

- Start small, one HAC, one PFA, one committee, one department
- Use PDSA
- Allow for changes and adapt as needed
- Measure
- Build knowledge
- Include patients and families

Implementation

- One area or department
- Change is the new standard
- Implement steps to hardwire
- Prevent back sliding to "the way it was done"
- Continue to measure
- Promote success
- Include PFAs in training and implementation

Spread

- Implement the strategy across all departments
- Widely share the innovation
- Adapt where needed
- Hospital or Healthcare system wide
- Include PFAs
Preparing PFAs to Partner in QI Work

1. Frame the issues
2. Discuss just culture vs blame culture
3. Introduce PFA to key players before first committee meeting
4. Teach system and human factor theory
5. Teach current QI strategies and methods
6. Assign PFA a QI buddy

Organizational Accountability

- Prepare the organization
  - Staff prepared to work in partnership with advisors
  - Staff understands the value of a PFA
  - Infrastructure to support the Advisors
  - Infrastructure to support the team
  - Leaders “own” this

Identifying and preparing Patient Family Advisors for QI work

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Why Utilize PFAs in QI efforts?
1. Provides a patient and family perspective
2. Challenges the way things have always been done
3. Partnership equals innovative ideas

Choosing Effective PFAs

An effective advisor:
- Has personal patient experience or has acted as a caregiver
- Has processed through grief or loss
- Can generalize personal experience to provide feedback on overall patient experience
- Has time to commit to regular meeting attendance as well as outside volunteer opportunities

Choosing Effective PFAs

An effective advisor:
- Possesses soft skills necessary for working in a collaborative environment:
  - Active listening
  - Clear, tactful verbal communication
  - Willingness to speak in front of group/leadership
  - Does not have a single focus or agenda
PFA Training Components

- Clarification of PFA role in this context
- Background on what is to be improved addressing with QI methodology
- Review of communication strategies
- Overview of QI process

Building the Team

- What does each person bring?
- What expertise is in the room?
- How will we work together?
- What orientation can we all participate in?

Sharing Data

- What data are you using?
- What is important for the Advisor to know
- What is known and understood by staff
- Recognize that some info will be new to PFAs
  - Ie. Why are people falling?
  - Recognize the learning curve
  - Make room for potential emotions
Including Patients and Families

- Improves care
- Bring renewed interest
- Surge of energy
- Reminds us who we are doing quality work for
- Can bring joy back into the work place

Tools for Partnering with Patient Family Advisors

- PFAC
- PFA on Internal Committees
- PFA Rounders
- Staff Interviews
- Patient Safety Rounds
- Secret Shoppers/Quality Observers
- PFA on RCA
- Story Telling

What is a PFAC?

A Patient and Family Advisory Committee (PFAC) is a group of patients, family members, office staff, and providers working together to improve safety, quality, and the patient experience.
Patient/Family Advisory Councils

- Identify and implement ways of improving the care experience for all patients and families
- Discuss and plan changes to improve hospital quality and safety
- Identify ways of improving the care experience for all patients and families
- Council members include patients, families, hospital staff, and clinicians

What a PFAC is Not

- A place to sort out personal grievances
- A place to focus on personal agendas
- A grumpy, whiney patient group

Why Have a PFAC?

- Bring a new perspective and experiences
- Change culture to authentically partner with patients
- Challenge the way things have always been done
- Use your untapped resource
Steps to a PFAC

Determine Goals and Mission

Prepare Leadership and Staff

Recruit Orientation Meetings and Projects

Sustaining and Grow

Who makes a good PFAC Member?

- It isn’t what they say but how they say it
- Listens with an open mind
- Can work in a group with differing ideas
- Represents multiple voices and listens to multiple voices
- Build a PFAC that is representative of the community being served!

PFA on Internal Committees

- Changes the culture:
  - Greater awareness and respect for patient/family needs and experiences
- Patient perspective will be weighed in decision-making process
- Leaders learn the “real-life” results of their decisions
Prep staff prior to PFA participation

- Discuss goal for including PFA in meeting/project
- Adjust expectations when necessary
- Request member be introduced at start by chair
- Assign a “buddy”
- Request updates on how it’s going

Which Committees?

- Patient Safety/Quality
- Patient Experience
- Improvement
- Facility planning
- Information technology
- Ethics
- Lean Projects
- And others

ALL OF THEM!!

Peer Rounding

- Prepare PFA and nursing
- Visit is social with a purpose
  - What is going well?
  - What could we do better?
- Option of targeting specific topics
Example: Readmissions
Readmission-Focused Peer Rounding

Staff Interviews

**WHO:** Any and *all* potential new hires

**WHEN:** During final rounds of interviews

**WHY:**
- See the candidate through the eyes of a patient/family member
- Get immediate feedback on candidate's ability and willingness to engage patients
PFA Safety Rounds

PFA Patient Safety Rounds

- **Who**: PFA, Frontline staff, senior leaders, members of PS committee
- **What**: Provide checklists, pens, clipboards
- **Where**: All Departments
- **When**: varied to cover different departments
- **How**: Prepare team, plan de-brief, communicate findings

Secret Shopper or Quality Observer

1. Follow an active patient
2. Passive observer (waiting room)
3. Observe an actual patient experience
4. Present as a patient
5. PFAs who become actual patients
Table Talk

1. Where could you use a Quality Observer?
2. What resources would you need to implement a Quality Observer Program?

PFAs in Root Cause Analysis (RCA)

Current patient safety event reporting systems are aimed at obtaining information from health care providers. However, patients and their family members are in a unique position to view the continuum of care, which enables them to identify gaps in care that may have contributed to adverse events (Battles 2014).

Preparing PFA to be on an RCA

- Training and individualized preparation
- Understanding the importance of confidentiality
  - Beyond the fear of lawsuits
    - Private healthcare information
- Understanding of national landscape of medical errors
- Review of types of cases that are brought to an RCA
- Training in improvement methods
- Understanding of system theory
- Understanding of human factors
  - Understanding of financial impact to the hospital and patients and families
- Have a feedback loop
Preparing RCA committee to work with PFA

- Explanation of the importance of including the patient's perspective
- Understanding of the role of the PFA and their training
- Examples from other organizations
- Understanding of the benefit to the hospital and the RCA work
- Open discussion of perceptions and concerns
- How the committee can adapt to including the PFA
- Have a feedback loop
- Include RCA staff in preparing and implementing PFA training

Facts bring us to knowledge, but stories bring us to wisdom.
Rachel Naomi Remen, M.D. Kitchen Table Wisdom

Why do we tell our stories?

- To make it real
- To connect with others
- To make a difference
What Makes a Story Impactful?

- Descriptions versus Judgments
- Impact versus Intent
- Facts versus Opinion
- Personal versus Emotional
- Teach versus Chastise
- Change versus Punish
- Describe versus Punish
- Information versus Repetition
What Strategy is Going to Fit?

• What are you looking to improve?
• Which strategy might work?
• What is your first step?

Start small

• Plan, Do, Study, Act
• Choose one PFA
• One project
• Small tests of change
• Review with everyone
• Adjust as necessary

Key to success: Prepare, Prepare, Prepare

• Leadership
• Staff
• Patient Family Advisors

You are not alone...there are a lot of resources and assistance available!
Tanya Lord PhD, MPH
tanyalord@comcast.net