



## PATIENTS AS QUALITY PARTNERS

Ronette Wiley, RN CPPS  
February 8, 2013

### WHY ENGAGE PATIENTS AND FAMILIES?

There are a number of evidence-based strategies that can be utilized to prevent errors, hospital-acquired conditions, and other adverse events.

Where applicable, partnering with patients and families can advance this work.

The old adage “two heads are better than one” most definitely applies to healthcare quality and safety!

### THE LOCAL BACKGROUND THAT INSPIRED CHANGE (2006)

- 70% of nurses in non-critical care units had less than two years experience.
- Serious “wrong patient” medication error
- “Near Miss” wrong side surgery
- Joint Commission had not yet developed “speak up” program

### THE CHALLENGE

To find a way to engage patients and families in preventing errors and improving safety that would not simultaneously put the care team “on the defensive” or make them feel like “they are being watched”.

### THE SOLUTION

- Multidisciplinary team composed of physicians, nurses, techs, administration, infection control, and PATIENTS/FAMILIES came together to develop a program.
- Targeted patient education (written and scripted) that is reviewed at the time of admission and reinforced throughout an inpatient admission

### AREAS OF FOCUS

#### PATIENT IDENTIFICATION:

If you are being admitted to the hospital, you will have an identification band placed on your wrist. Offer to show your ID wristband to staff when they enter your room. You can expect staff to check it before giving you medications, drawing blood, or taking you for procedures. If they do not, please ask them to. If your wristband has to be removed for any reason, you can expect staff to replace it.

## AREAS OF FOCUS

### HAND HYGIENE

“You can expect nurses, physicians, and other caregivers to cleanse their hands with disinfectant soap or hand gel before and after patient contact. Feel free to ask your caregiver if they have washed their hands before providing care to you”.

Bonus strategy: Gave staff big lapel pins that said ASK ME IF I'VE WASHED MY HANDS!

## AREAS OF FOCUS

### MEDICATION SAFETY

- You can expect staff to stay at your bedside until you have taken medications they gave you. Leaving a cup of medications at the bedside is prohibited.
- Make sure your physician knows what medications you are currently taking. This includes prescription and over-the-counter medications, and supplements such as vitamins and herbs.
- Alert your physicians and nurses about any allergies you may have had to medications in the past.

## AREAS OF FOCUS

### STAFF IDENTIFICATION

You can expect staff to introduce themselves and tell you what they are doing. All staff can be identified by their badge, which has their name and photo image.

## AREAS OF FOCUS

### Universal Protocol

If you are scheduled for surgery, you can expect staff to confirm the correct location of your surgery and mark the correct site.

## PREPARING THE CULTURE: LOTS OF MEETING AND PAVING...

### Talking points for staff – Some of the reasons why this is important:

- Bassett is proactively engaging in this work based on evidence that involving patients in their care and educating them about safety practices has the potential to reduce errors and unsafe acts.

## PREPARING THE CULTURE: LOTS OF MEETING AND PAVING...

We know we can reduce the potential for patient safety problems by following simple “rules”. For example:

- Checking a patient’s wristband prior to drawing blood or giving medication can prevent errors.
- Handwashing is the most important way to prevent the spread of infection in hospitals.
- Studies prove that patient’s meds should not be left at the bedside. On average, 50% of the time when a cup of meds is left at a patient’s bedside, the meds are never taken by the patient

### PREPARING THE CULTURE: LOTS OF MEETING AND PAVING...

- Patients have excellent “safety eyes and ears”. They have a personal investment in ensuring their safety. We want to capitalize on that investment.
- The Joint Commission is requiring hospitals to involve patients in hospital safety as one of their 2007 National Patient Safety Goals...we want to be ahead of this

### TRAINING STAFF ABOUT THE PROCESS

- Each admission packet will have a partnership document placed in it
- The admissions nurse will review the document with the pt and/or family during the admission process.
- If patients experience safety concerns or have safety suggestions, they are encouraged to speak with their physician or nurse. Alternatively, they will be provided with the Patient Representative Services number.
- Staff hand hygiene buttons stating “Please ask me if I’ve washed my hands” have been developed and patient care staff are encouraged to wear them on their uniforms.
- Hospitals that have been the most successful in improving hand hygiene report that this visual cue has been extremely helpful.

### PREPARING STAFF FOR A MORE SOPHISTICATED PATIENT

As patients become more sophisticated about safety, we can expect them to ask questions:

- “Did you wash your hands?”
- “Do you want to see my wristband?”
- “What are these medications?”

These are questions we *want* them to ask. Answer these questions professionally, not defensively. Remember, we are asking patients to partner with us. Let’s answer their question and thank them for asking. That’s a true partnership!

### CLOSING THE FEEDBACK LOOP ON THE PROGRAM

Employees can expect to get feedback on the results. We have developed a patient safety partnership “scorecard” that will tell us how successful we are. Things such as “wrong patient” medication errors, hospital acquired infection rates, and patient safety complaints are monitored. Each department receives quarterly summary of results in a dashboard format.

### MEASURES OF SUCCESS

- Hand hygiene compliance
- Hospital acquired c-difficile rates
- Hospital acquired MRSA rates
- Wrong patient med error rates
- Universal Protocol compliance
- Staff ID badge compliance
- Patient complaints related to safety
- Alcohol gel usage by volume
- Compliance with patient ID processes

### SUSTAINABLE OUTCOMES

- Hand hygiene compliance improved 30%
- Hospital acquired c. difficile rates decreased 50%
- Hospital acquired MRSA rates decreased 28%
- Wrong patient medication errors decreased 90%
- Patient complaints related to safety decreased to zero.
- 100% compliance with staff wearing ID badges

## LESSONS LEARNED

- Very little cost associated with program (lapel buttons, cost of printing the partnership document)
- Easier to engage “new” staff in this...may not have old/bad habits yet.
- Small % of medical staff remained indignant when patients asked if they had washed their hands (particularly true of surgeons!)
- Must keep up with the scorecard of results.
- Great way to promote healthy competition among units.
- Very popular with patients and families. Big satisfier!

THANK YOU!