

## BACKGROUND

Celebrating its 125<sup>th</sup> year of service, St. Joseph Medical Center (SJMC) remains committed to providing safe and effective care. Continuous national media coverage regarding safety issues in hospital care has created an atmosphere of distrust among patients and their families nationwide.

No longer content to "roll with the punches," and armed with the knowledge that medical errors is listed as the 8<sup>th</sup> leading cause of death in the U.S., the team at SJMC developed the Patient Safety Champion Program (PSC) in February 2012, in order to raise awareness and motivate colleagues to directly impact patient safety.

The PSC's have focused on 3 specific areas to enhance both patient care and patient safety including: patient satisfaction, medication safety, and prevention of patient falls.

Since its inception, the PCS's have developed into a cohesive team, demonstrating measurable positive outcomes, setting the stage for an enhanced culture of safety, awareness, and accountability.



St. Joseph Medical Center,  
Houston, Texas

## PURPOSE

**The Mission of the Patient Safety Champion Program**  
Raise awareness and motivate colleagues in adopting and hardwiring safe practices to improve patient outcomes and establish a culture of quality within the organization.

The Role of the Patient Safety Champions –

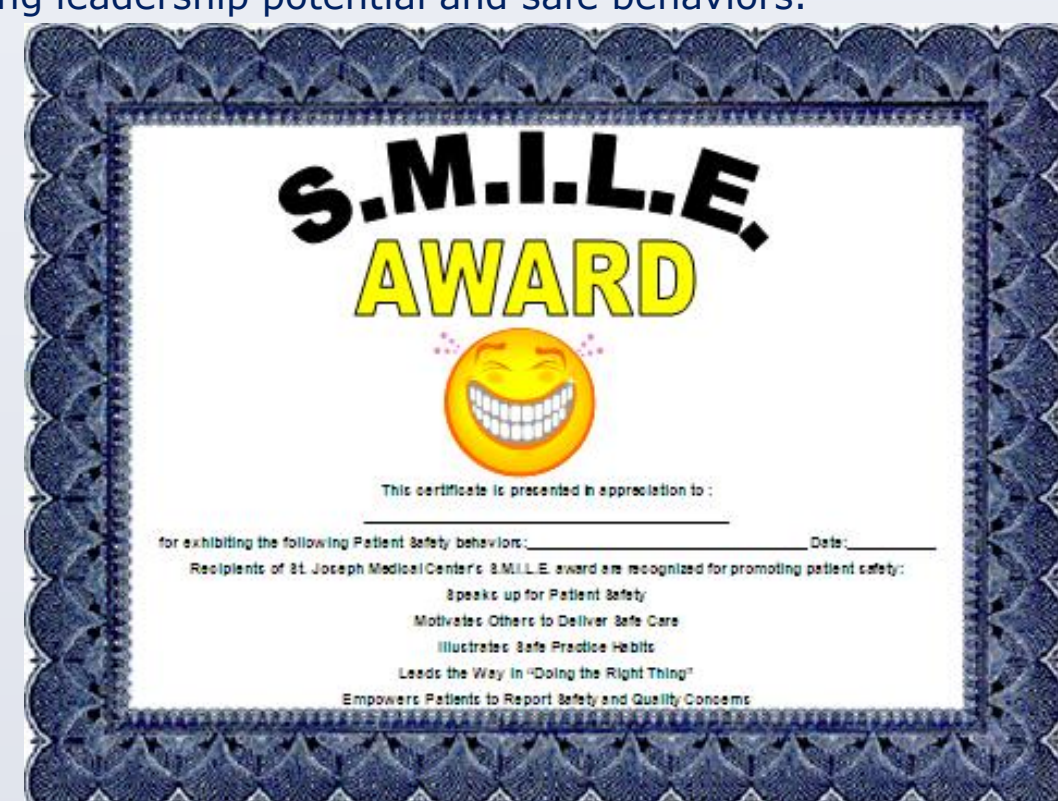
- Serve as a resource for your unit/department regarding patient safety initiatives
- Survey staff safety behaviors
- Recognize & reward safe behaviors
- Participate in patient safety & PI activities
- Present up to date information in monthly department staff meetings related to:
  - PI team activities
  - Policy/process revisions
  - Best practices
  - Trends in reported medical errors
  - Serve as liaison for staff concerns/questions
  - Observation audits
  - Identify candidates for SMILE awards



**"If I can change and you can change, everybody can change!"**  
Rocky Balboa, ROCKY IV (1985)

## STRATEGY/IMPLEMENTATION

Following a rigorous selection process, the Patient Safety Champions attended the first of many monthly meetings known as the "Breakfast of Champions" to review data, discuss initiatives and recognize and reward individuals leading the way in safe behaviors. PSC's facilitate identification of hazardous conditions affecting patient care and causal factors contributing to medical errors. Initial program priorities focused on improvement in fall prevention, medication safety, and medical error reporting. In collaboration with Quality and Risk Management Departments, PSC's evaluate current processes, share best practices as well as performance improvement and patient safety information. Specially designed red polo shirts bearing golden boxing gloves ensure PSCs stand out during rounds and at meetings. The PSC program encourages engagement and communicates the organization's commitment to a culture of quality and safety in a uniform manner by line level staff. This role is an honor, recognizing leadership potential and safe behaviors.



The Patient Care Champions identify staff from their areas to nominate for the SMILE award. Included are volunteers, clinical staff, non-clinical staff, physicians, students, and residents.

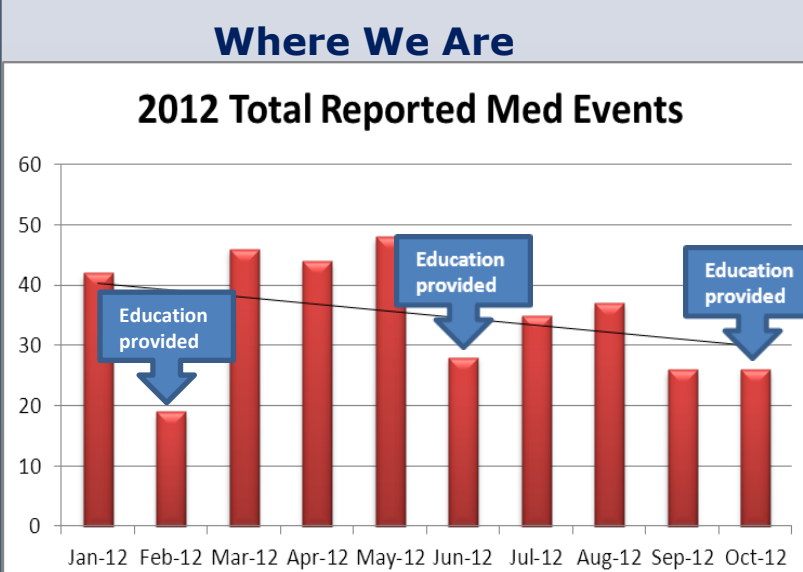
- S** – Speaks up for patient safety
- M** – Motivates others to deliver safe care
- I** – Illustrates safe practice habits
- L** – Leads the way in "doing the right thing"
- E** – Empowers patients to report safety and quality concerns

These key behaviors are essential for building an engaged culture of safety. Recipients of the SMILE Award receive a certificate, goody bag and pictures are posted in recognition of their efforts.

## MEDICATION SAFETY

### ACTIONS:

- Reduce medication-related events
- Review trends in reported events to identify opportunities for process improvement
- Conduct audits to assess actual practice
- Identify and help operationalize best practices in medication management



Aggregated data demonstrates no consistent trend, but education consistently improves results.

### ANALYSIS:

- Improved reporting needed to identify:
  - Potential risks: hazardous conditions hidden in the medication management process
  - Actual errors that affect patient care
  - Causes of errors
  - Error prevention strategies
  - PSCs role in improving error reporting:
  - Educate staff on reportable errors
  - Survey staff knowledge related to reportable medication events

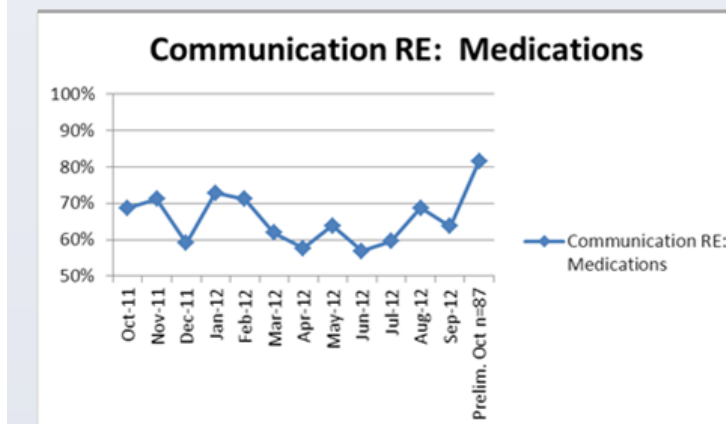
## HCAHPS IMPROVEMENT

Patient Safety Champions serve as a great resource and have expressed interest in working on many different aspects of both safety and quality initiatives. Having struggled organizationally with the HCAHPS indicator related to purpose and side effects of medications, our champions adopted the task of educating staff on what they can do to impact Communication regarding Medications.

**ACTIONS:** PSC's conducted a flash survey on their units to determine current knowledge of HCAHPS survey tool and high priority targets. Based on feedback PSC's educated staff (using info below) on the HCAHPS questions and how they could improve results. Our Champions ensured scores were posted and discussed during staff meetings. In addition, they shared the location and appropriate use of the KRAMES as an educational tool for staff.

**ANALYSIS:** Since the time our champions administered the HCAHPS flash survey, in late June, scores have moved from 60% always to 82% always response in October. We look forward to continued HCAHPS improvement during the next few months.

HCAHPS Question	Current Score	Target Score
"Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?"	75%	85%
"Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?"	65%	75%
"Your doctor, nurse, pharmacist, or other health care worker explained to you why you were taking the medicine and what it could do for you?"	70%	80%
"How often did hospital staff tell you what the medicine was for?"	75%	85%
"Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?"	65%	75%



## FALL PREVENTION

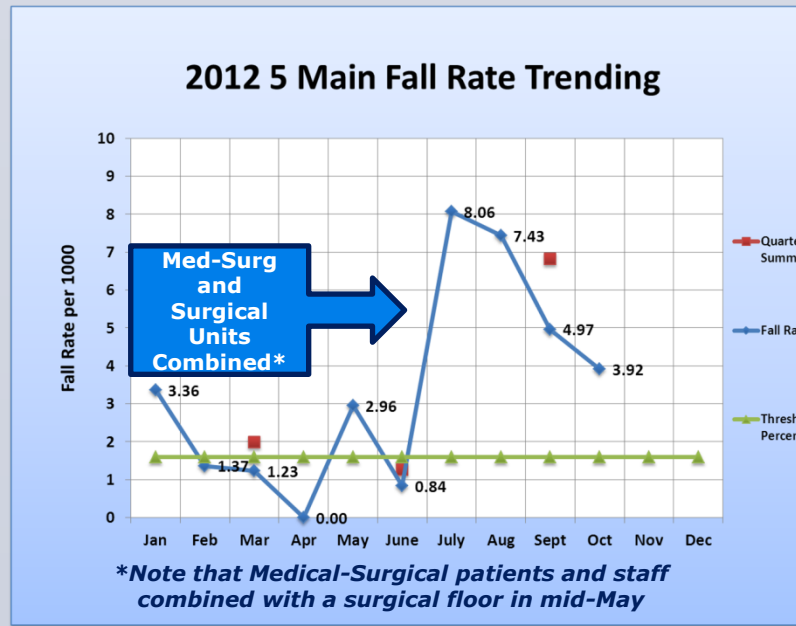
Patient Safety Champions began working on fall prevention with a Medical-Surgical floor (5 Main) prior to launching the plan house-wide. 5 Main was selected as our pilot unit. In early spring, two units (8 Main – Medical Unit and 5 Main, Surgical Unit) were collapsed into one service area. The new unit combined both departments existing staff and the combination of both medicine and surgical patients on one floor. These changes presented multiple challenges with the expanded patient mix and provided ample opportunity for improvement.

**ACTIONS:** Initiatives that PSC's assisted in implementing:

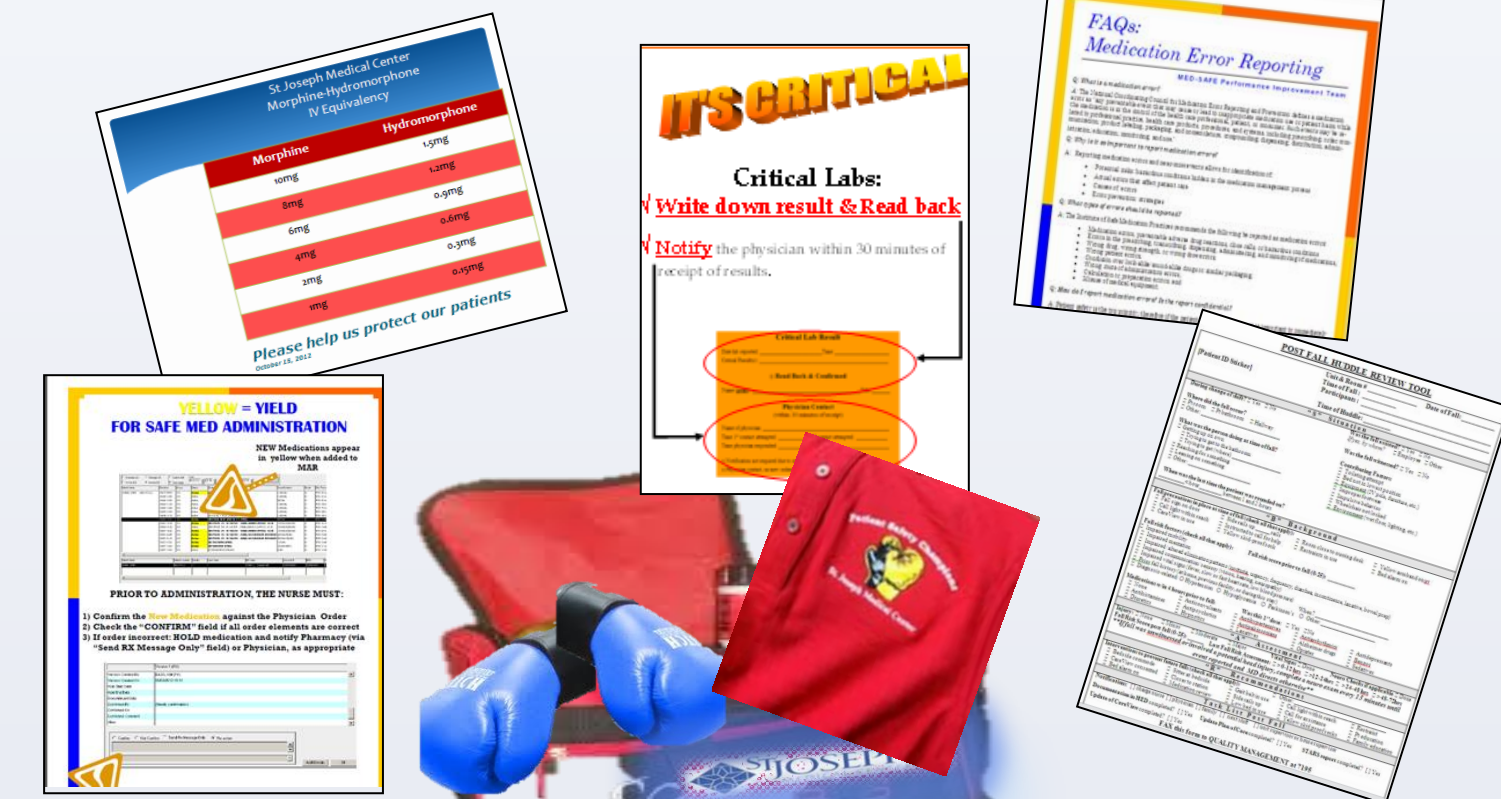
- Presented fall data monthly to staff to increase awareness and empower them to have an active role in fall prevention
- Fall Prevention Policy was revised; added risk assessment procedures for the outpatient areas; expanded prevention strategies
- Expanded identification of patients at risk with yellow banding, yellow socks, and yellow falling star on patient's door
- Initiated hourly rounding on unit to include the 3 P's (pain, positioning, potty)
- Initiated the utilization of Post Fall Huddles to debrief the staff after a patient fall and to identify possible contributing factors and potential preventative solutions.
- Educated majority of med-surg staff regarding hospital beds and correct use of bed alarms
- Introduced utilization of departmental gait belts with education provided by PT/OT
- Suggested bath mats to prevent falling in showers

### ANALYSIS:

Although much work remains, the overall fall rate frequently exceeded the established target of 1.6 NDNQI (25<sup>th</sup> percentile), there has been a significant downward trend noted since the initial combination of the units.



## TOOLS OF THE TRADE



PSC's have demonstrated initiative and drive to collect information and disseminate education to the unit populations. The tools (flyers, stickers, posters and data) are created and provided monthly to each of the team members with the expectation of immediate education on the unit. Targeted improvement initiatives are designed to address current trends in the data as well as safety and quality issues. Examples of the tools include: critical lab values stickers, post fall huddles, medication safety posters, HCAHPS, and other time-sensitive tools.

## CONCLUSIONS

Since its inception, the Patient Safety Champion program has produced measurable outcomes and enhanced the culture of safety. Though still a work in progress, during the first few months of data, we see positive trends in reporting of medication events, increasing patient satisfaction scores, and a shift in staff awareness and ownership. Through auditing, education, and recognition, our Patient Safety Champions continue to target areas for improvement utilizing NDNQI benchmarking, HCAHPS measures and other safety tools. Our Champions have become well rounded bedside leaders who can see the possibility of impact across the spectrum of indicators.

## CONTACT

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