Impacting Patient Safety and Patient Satisfaction

Jennifer L. K. Davis, MS, RD
Hawaii Dietetic Association
May 5, 2011

At the airport.....

Objectives

- Understand HCAHPS and Patient Satisfaction surveys and how your practice can impact these scores.
- Review The Joint Commission (TJC) standards that impact Nutrition Services and affect Quality.

My objectives.....

.....We going to talk about aviation, patient safety, patient satisfaction, improved communication, congenial interactive teams, and most important how you as an RD can impact the patient experience and be a leader in your organization.....

Forward : Why Hospitals Should Fly

" . . . The culture of health care is not only unsafe, it is incredibly **dysfunctional.** Though the culture of each health care organization is unique, they all suffer many of the same disabilities that have so far effectively stymied progress: an authoritarian structure that devalues many workers, lack of a sense of personal accountability, autonomous functioning, and major barriers to effective communication." Lucian Leape-

Why Hospitals Should Fly....

The cockpit of a plane can be like a hospital with the pilot, the co-pilot, the engineer.....

Similar to a ED, an OR suite, or an ICU with the attending MD, surgeon, head nurse, anesthesiology tech....scrub nurse etc....

1977 1999

Tenerife crash
March 27th, 1977

To Err is Human:

Building a Safer Health System is a report issued in November 1999 by the U.S. Institute of Medicine that may have resulted in increased awareness of U.S. medical errors.

The report was based upon analysis of multiple studies by a variety of organizations and concluded that between 44,000 to 98,000 people die each year as a result of preventable medical errors

Tenerife

583 fatalities

"The best and the brightest"

- Captain **Jacob van Zanten** was the Chief Pilot for KLM, a Vice President, head of their safety program, a veteran pilot with over 30 years of experience, and poster child in their ad campaign.
- **KLM** jumbo jet attempting to take off crashed into a **Pan Am** jumbo jet that had not yet cleared the runway, resulting in 583 deaths.
- Two other people in the crew had concerns about the attempted takeoff but each acquiesced to the captain's wishes to take off.

Culture Change

"The fact that this accident could happen to people with outstanding records forced everyone in the industry over the next decade to focus on the systems of safety and develop crew resource management (CRM), remove the powerful hierarchical structure in the cockpit, and other changes that helped mold **a totally new culture of safety and teamwork in which all parties in a flight had equal voice.**"

~ **100,000 people dying each year from medical negligence.**

~ **It is roughly equivalent to one 747 jetliner, filled with passengers, crashing every day of the week.**

St. Michaels…

- That basic theme is that "**Culture kills strategy every time**"

Lessons Learned:

- Highly congenial **interactive**, **team**-based environment.
- Accept Human failure
- Moving from 90/10 to 50/ 50 rule
- Last chance is the best chance- UP/ Time Out

Your risk of dying in a plane crash is around 1 in 9,000,000.

People in hospitals run an almost 1 in 5 risk of suffering medical negligence.

Cost of Medical Errors in U.S.

- $37.6 billion year
- $17 billion costs associated with preventable errors
  - –50% of the $17 million are for direct health costs

– IOM, 1999

October 7, 2007 - October 6, 2008

Category and Type	Number	Background
Surgical/Invasive Procedure Events		
Surgery/invasive procedure on the wrong body part	1	Deaths: 0 Serious Disability: 0 Neither: 1
Wrong surgery/invasive procedure performed	1	Deaths: 0 Serious Disability: 0 Neither: 1
Care Management Events		
Stage 3 or 4 pressure ulcers (serious bedsores)	4	Deaths: 0 Serious Disability: 0 Neither: 4
****New Event Categories for 2008**		
Serious disability associated with: A fall while being cared for in a facility	3	Deaths: 0 Serious Disability: 3 Neither: 0
Unstageable pressure ulcers	8	Deaths: 0 Serious Disability: 0 Neither: 8

Joint Commission Resources, 2009

Everyone commits errors

- Communication failure
- Lack of effective training
- Memory lapse
- Inattention
- Poorly designed equipment
- Exhaustion, fatigue
- Ignorance
- Noisy working conditions
- Other personal and environmental factors

"Swiss Cheese Model"

Accidents result from multiple factors not a single failure

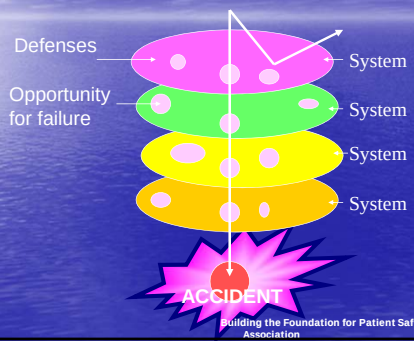
Many defenses (layers) exist to deflect failures

But, multiple failures align so error occurs

System review can help identify how failures get through the defenses

Building the Foundation for Patient Safety, Florida Hospital Association

Swiss Cheese Model



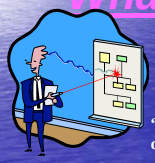
Building the Foundation for Patient Safety, Florida Hospital Association

Key Learnings of Swiss Cheese Model

- Systems that rely on error-free performance are doomed to failure
- Humans make mistakes
- Continue to strive for perfection but realize humans are not perfect

Building the Foundation for Patient Safety, Florida Hospital Association

Not *Who* caused the accident but *What* caused the accident?



"Medical errors most often result from a complex interplay of multiple factors. Only rarely are they due to the carelessness or misconduct of single individuals."

Lucien L. Leape, M.D.

Building the Foundation for Patient Safety, Florida Hospital Association

Team Training / Behavioral Based Expectations

- **Congenial Interactive Teams**
  - Everyone speaking up
  - Questioning attitude
  - Pay attention to detail
  - SBAR
  - Leave no doubt
  - "CUS" words
- Communicate Clearly
  - Read backs
  - Clarifying questions
- Have a questioning attitude
  - Validate and Verify
  - Policies and Procedures
- Blameless culture

Communication errors

- 12.5% percent of the time we hear something incorrectly ~ Human error
- Common in Aviation Disaster
- Common in Healthcare
- Pivotal Factor in 65% of Sentinel Events
- Joint Commission 3,000 events 1995-2005
- Primary contributing factor in adverse events 70-80% of root cause analysis reports

-National Center for Patient Safety (2006). Root Cause Analysis Database

"Leave No Doubt"

Communicate clearly – Give the correct information in a timely and accurate manner

Communicate Clearly
Tools/techniques

1. Repeat backs - (when information is transferred)
2. Read backs (for *ALL* telephone orders and *ALL* critical test results)
3. Clarifying questions (ask 1-2)
4. Phonetic/numeric clarification (sound alike words or numbers)

"Leave No Doubt"

Ask 1 to 2 clarifying questions

- When in *high risk* situations
- When information is *incomplete*
- When information is *ambiguous (unclear)*

Communicate Clearly
Repeat Backs

1 **Sender initiates** communication using Receivers Name. Sender provides an order, request, or information to Receiver in a clear & concise format.

2 **Receiver acknowledges** receipt by a repeat-back of the order, request, or information. **Information must be written down and READ back to the Sender.**

3 **Sender acknowledges the accuracy** of the read-back by saying, "That is correct." If not correct, Sender repeats the communication.

Clear Communication and Empowerment

Hurley, Team Stepps

Mutual Support

Please Use CUS Words
but *only* when appropriate!

Hurley, Team Stepps

33

Skill Demonstration

Debrief Checklist

TOPIC	
Communication clear?	
Roles and responsibilities understood?	☑
Situation awareness maintained?	☑
Workload distribution	☑
Did we ask for or offer assistance?	☑
Were errors made or avoided?	☑
What went well, what should change, what can improve?	☑

Hurley, Team Stepps

34

Building the Culture to Minimize Harm

LEADERSHIP

R

D

Staff and patients are comfortable talking about errors, and a structure and processes are in place for reporting and analyzing errors, near misses and risks.

Staff and Patients report and communicate about risks

Identify Risks

Correct Risks

Minimize Harm to Patients

Joint Commission Resources, 2009

What is a Safety Culture?. according to TJC

- All individuals are focused on maintaining excellence in performance.
- Leaders demonstrate a commitment to safety and quality.
- Committed to ongoing learning and **flexibility to change** in technology, science and the environment.

LD. 03.01.01

- Leaders create and maintain a culture of safety and quality throughout the hospital.
- Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization.

Safety Culture...John Nance

- The whole team acknowledges that errors will occur and the **team** will catch each other's mistakes before harm comes to patients.
- It is a high reliability organization and a learning organization in which all members take **pride in learning from their mistakes as much as celebrating their successes.**
- It is a culture in which teams are empowered and encouraged to do a root cause analysis on the spot and make changes to the system immediately (ala Toyota/lean thinking concepts).

Focus of attention is on the performance of systems and processes instead of the individual– (blameless)

The Joint Commission has identified five Patient Safety Goals & 1 Universal Protocol to improve patient safety:

1. Improve the Accuracy of Patient Identification
2. Improve the Effectiveness of Communication among Caregivers
3. Improve the Safety of Using Medications
4. Reduce the Risk of Healthcare-Associated Infections
5. The Organization Identifies Safety Risks Inherent in its Patient Population

U.P. Prevent wrong-site, wrong-procedure and wrong patient procedures

1. Improve the Accuracy of Patient Identification

Standard:

- Use at least two (2) patient identifiers.

Patient Identifiers must be used….

– When administering medications

– When administering blood products

– When taking blood samples & other specimens

– When providing any other treatments or procedures

Patient Identification

How many people would have thought that a patient could be severely harmed due to misidentification for a food tray?

Hand Hygiene

This week, the World Health Organization (WHO) launches its annual global campaign, SAVE LIVES: Clean Your Hands.

"Healthcare-associated infections are the most common adverse events in hospitals ---- harming hundreds of millions of patients around the world ---- and proper hand hygiene can prevent many of them.

Hand hygiene can also help stem the rising tide of dangerous, often lethal, multi-resistant bacteria."

How is your staff doing????

4. Reduce the Risk of Healthcare-Associated Infections

Standards:

- Comply with CDC hand hygiene guidelines.
  Hand Hygiene Team monitors staff compliance with hand hygiene.

Speak up!

4. Reduce the Risk of Healthcare-Associated Infections (cont'd)

Standards:

- Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms.
- Implement evidence-based practices to prevent central line-associated bloodstream infections.
- Implement evidence-based practices for preventing surgical site infections.

Nutrition Care protocols / Hand Hygiene / Reduced TPN

Universal Protocol: Prevent Wrong-Site, Wrong-Procedure and Wrong Patient Procedures

- Conduct a **pre-procedure verification** process.
- **Mark** the procedure site.
- Implement a **TIME OUT** immediately before starting the procedure to confirm:

Standards Related to Food and Nutrition

PC 02.01.05

- Hospital Provides Interdisciplinary, Collaborative Care

Standards Related to Food and Nutrition PC 01.02.03

- Hospital Assesses and Reassess the Patient and his or her condition according to defined time frames
- Time frames for nutrition assessment and reevaluation of nutritional risk
- The hospital completes a nutritional screening (when warranted by the patient's needs or condition) within 24 hours after inpatient admission.

PC 01.03.01

- The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
- Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. *Is the patient or family involved?*
- The hospital revises plans and goals for care, treatment, and services based on *the patient's* needs.

Standards Related to Food and Nutrition

- PC 02.03.01
  Hospital Provides Patient Education and Training
  Discharge education plans and referrals
  Beware of patient's preferred language needs
- PC 02.02.03
  Hospital makes Food and Nutrition Products available to Patients–
  Food safety and substitutions

Compliance Tips

- Implement regular tracer methodology with RD's, dietary aids, kitchen staff. Always be survey ready. Educate staff.
- Trace complex patients with special needs
- Review current criteria for initiating referrals to RD's– time frames and process
- Review all policies– update if needed.
- Ensure RD involvement in TPN
- Refrigerators– make sure temps are accurate
- Competencies
- Be on the look out for safety issues ☺

The HCAHPS (*Hospital Consumer Assessment of Healthcare Providers and Systems*) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.

CMS "Value Based Purchasing"

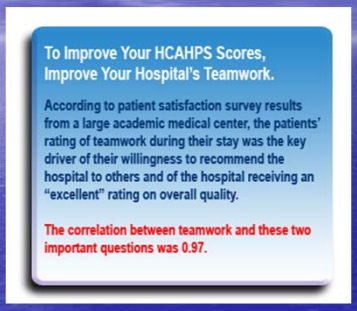
- Under CMS's "value-based purchasing" proposal, Medicare will withhold 1 percent of its payments to hospitals starting in October 2012, putting those funds into a pool to be distributed as bonuses to hospitals that score above average on several measures.
- Patient satisfaction scores would determine 30 percent of the bonuses, and clinical measures for basic quality care would decide the other 70 percent.

Changes in Healthcare 2008-2012

- Hospital acquired conditions (HAC) will receive less reimbursement from both Medicare and Medicaid– payments will be cut by 1% in 2014.
- Medicare will increase payments for reduction of Hospital Acquired Infections in 2012.
- Medicare payment reduced for high readmission rates in 2012
- Reduction of approx $7.1billion

HCAHPS

- The **HCAHPS** survey contains 18 patient perspectives on care.
- Eight key topics:
  - Communication with doctors
  - Communication with nurses
  - **Responsiveness of hospital staff**
  - Pain management
  - Communication about medicines
  - **Discharge information**
  - Cleanliness of the hospital environment
  - Quietness of the hospital environment.



Hospital Survey of Patient Safety Culture

Recently a correlative study was conducted by Westat, the company that administers the Hospital Survey of Patient Safety culture (HSOPS).

The study revealed that patient safety culture is strongly correlated to patient satisfaction.

This correlation is especially related to *teamwork within units* and staffing levels.

A.....GREAT Patient Experience

Wendy Leebov

- "The quality patient experience doesn't happen by accident." "
- "If it happens, you can bet is was designed."
- "A consistently GREAT patient experience is not a matter of attitude, awareness or positive intent."

The Quality Patient Experience, Wendy Leebov

Who are our customers?

Wendy Leebov

- "We are not Disney."
- "Our customers are highly anxious."
- "To create an exceptional patient experience, we need to focus on preventing or lessening anxiety for patients and families. "

The Quality Patient Experience, Wendy Leebov

Quint Studer—Individualized Patient Care

- **The Studer Group aim is to bring patient care to the bedside. The model includes:**

(a) Hourly Rounding

(b) Individualized Patient Care

(c) Bedside Shift Report

(d) Discharge Phone Calls

Studer

- Hourly rounding– uses key words to reduce patient anxiety.
- Individualized Patient Care- Finding out on admission what excellent care means to the patient.
- Address the patient by his / her preferred name
- AIDET Acknowledge Introduce Duration Explanation Thank-you

"Always responses" on the HCCAPS

Sample AIDET

- A Good morning, Mrs. Jones.
- I I am Jennifer Davis and I am the Registered Dietitian who will be doing your diet instruction today. I have been an RD for 20 years and have instructed thousands of patients on this diet.
- D This will take about 20 minutes. Shall we get started?
- E First we are going to start with a 24 hour diet recall. Tell me what your usual intake is on a typical day at home….
- T We are all finished. Thank you so much for letting me provide you with this information today and share in your care.
- Do you have any other questions? Is there anything I can do before I leave?

Press Ganey

- Nearly half of U.S. hospitals partner with Press Ganey for their HCAHP requirements and to improve their delivery of care.
- See what floor (s) has your largest respondents—target your efforts
- Respond to comments– make changes
- Moving "good" to "very good" or 4's to 5"s
- Recommend rounding and creating teams with nursing—see what issues affect nursing.
- It is not just about the food. Quality Temp **Courtesy**

HHS. Gov

- **HHS.GOV provides consumers the ability to find information on how well hospitals care for patients with certain medical conditions or surgical procedures, and results from a survey of patients about the quality of care they received during a recent hospital stay.**
- **Hospitals Compare website– you can compare local hospitals HCCAPS scores and find out about hospital acquired conditions (HAC's)**

The impact of the RD

- Member of the clinical team……add expertise to other interdisciplinary members.
- Rounding– *patient focused* not just meal rounds
- Focus on systems that need improving—order entry, EMR, tray delivery
- Patient Advocate—Communicate with the patient, MD, Nursing, FS
- Right patient Right tray
- Patient education and discharge instruction
- Clear concise diet orders

What about changing the rules?

Liberalized diets compare to
Liberalized visiting hours

Do we have any rules or practices that make it difficult for us to grant a simple request of a patient?

What do we say when we have to deny this wish?

How do you ensure that your response will not make the patient feel ***more anxious or powerless?***

The impact of the RD in Quality Care

- Early interventions
- Wound protocols
- CHF readmissions
- Communication of care plan to team including the most important team member—the patient.
- Advanced practice- research
- EN / PN protocols
- Communication with MD's and Nursing

Team work across units

- When healthcare teams negatively report ***teamwork across units*** and ***handoffs*** these also strongly correlate to negative patient satisfaction.
- Patients not only see and experience the loss of continuity of care, but they also must endure a sense of confusion among teams with poor teamwork across units.

Patient satisfaction best predictor of hospital quality

Researchers collected information on patients who had suffered heart attacks, heart failure, and pneumonia and observed patient satisfaction surveys regarding interactions with hospital staff and questions such as..

"Would you recommend this hospital to friends and family?"

Hospitals that scored well in these categories had lower readmission rates.

High readmission rates will be subject to cuts in Medicare reimbursements.

"**Quality** is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives."

William A. Foster

Take Home Message

"Patient safety culture and patient satisfaction are not two separate domains but rather intertwined parts of the same whole"

Carolyn Brady at the close of the Patient Experience and Patient Safety Culture conference, April 19-21, 2010

Your career journey…

- RD's taking flight and leadership roles within the organization…..
- Our skills have prepared us for hospital roles as valuable members of the health care team, department managers, directors, patient advocates, patient safety officers, accreditation specialists, safety specialists, PI coordinators…etc…

Hospitals will truly **fly** when……

"This is the way we have always done it," is finally recognized as the way it **should** never be done again. **…**

The sky's the limit….

References

1. Quality Improvement and The Clinical Nurse Leader in Today's Health Care Environment..Deborah M.Nadzam, PhD, FAAN, Joint Commission Resource
2. Food and Nutrition Update to the Standards for The Joint Commission Norma Kay Sprayberry, RN, MSN , Joint Commission Resources, Inc., 2010
3. 2010 Hospital Accreditation Standards, Accreditation Standards, The Joint Commission.
4. Quint Studer, The HCAHPS Handbook, Hardwire your hospital for Pay For Performance Success, 2010
5. To Err Is Human Building a Safer Health System Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors Committee on Quality of Health Care in America . Institute of Medicine National Academy Press, Washington, DC, 1999.
6. Simon R, Langford V, Locke A, et al. A successful transfer of lessons learned in aviation psychology and flight safety to health care: the Med Teams system. Proceedings of Patient Safety Initiative 2000: Spotlighting Strategies, Sharing Solutions; 2000 Oct 4–6; Chicago. Chicago: National Patient Safety Foundation; 2000. pp. 45–9.
7. Helmreich RL, Merritt AC. Culture at work in aviation and medicine: national, organizational, and professional influences. Brookfield, VT: Ashgate; 1998
8. Centers for Disease Control and Prevention
9. Use of liberalized diets in long-term care, RD 411
10. Why Hospitals Should Fly, John Nance.
11. Leebov Wendy, The Quality Patient Experience, 2010.
12. Building the Foundation for Patient Safety, Florida Hospital Association
13. Hurley, Wiliam. Team Stepps. Medical Team Training, Bringing Aviation Safety to Medicine. 2006.