E7: Patients as partners in healthcare

International Forum on
QUALITY & SAFETY
in HEALTHCARE
COPENHAGEN

Adapting to a changing world: equity, sustainability and wellbeing for all

@QualityForum #Quality2023

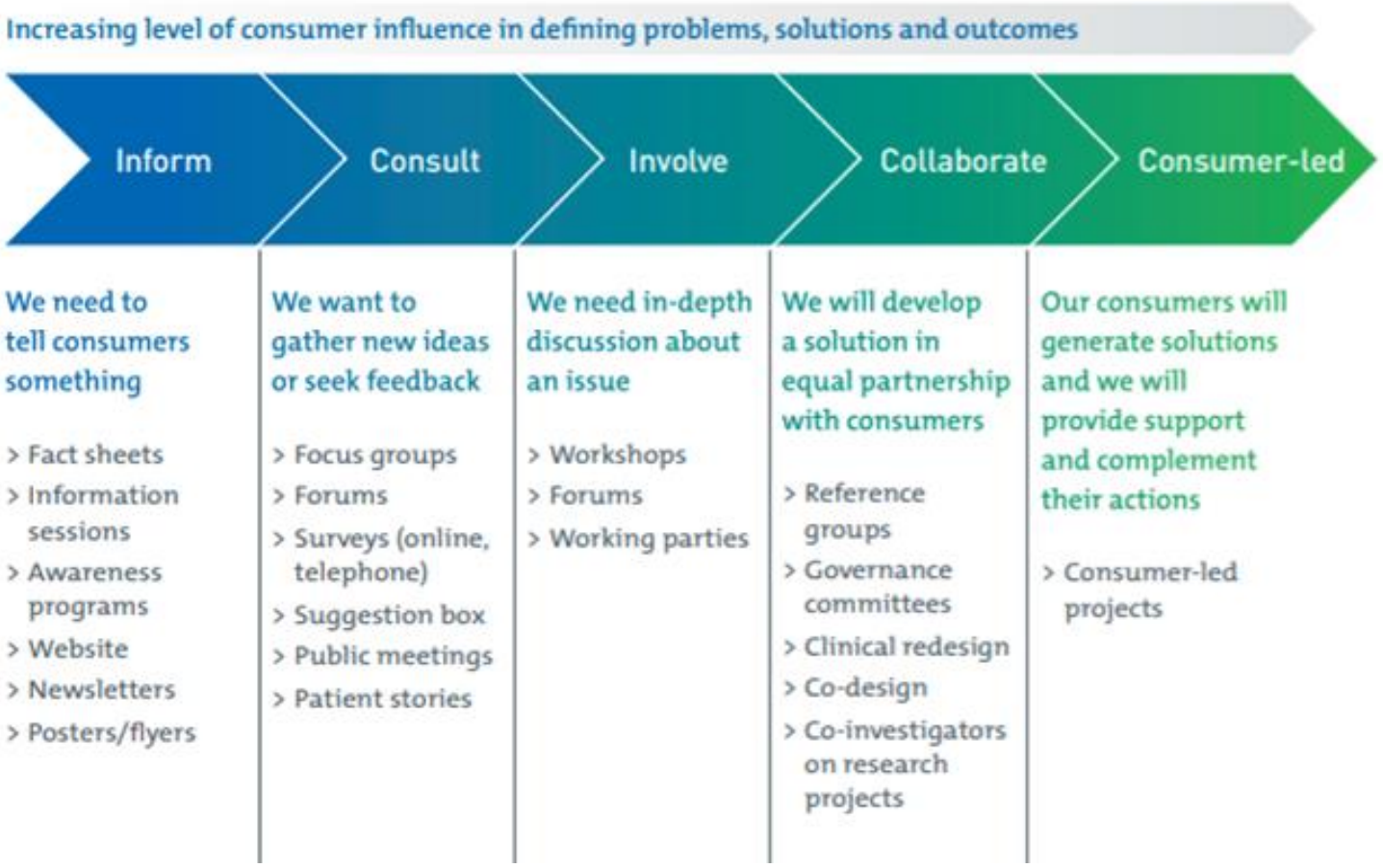
Institute for Healthcare Improvement

BMJ

Engaging a hospital network in consumer engagement

Presented by Sheila Daly and Lauren Lawlor
Epworth HealthCare, Melbourne Australia

Partnering with Consumers



Declaration of Interest

Thank you to the generous donors and sponsors of the Epworth Medical Foundation who awarded us a Maryjane Crabtree Staff Scholarship to support our attendance at this conference.

Acknowledgement of Country

Epworth HealthCare acknowledges the peoples of the Kulin Nations, the Traditional Custodians of the land upon which we work and care for our patients.

We honour the unique and continued spiritual connection that Australian Aboriginal and Torres Strait Islander peoples have to land, waters and culture.

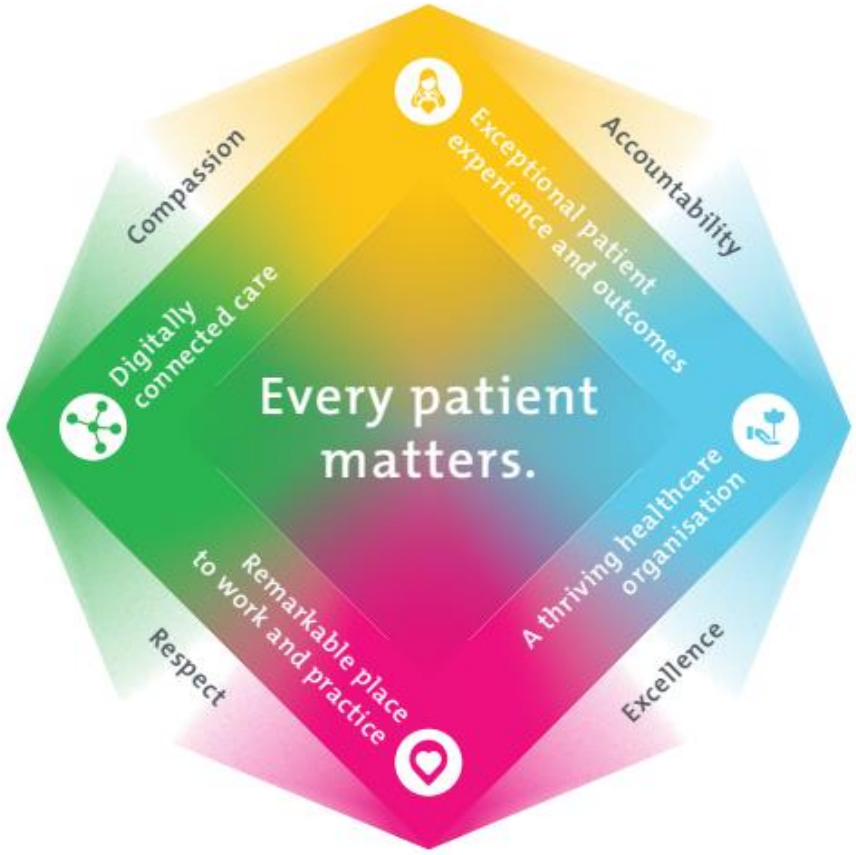
Epworth

Background

NSQHS STANDARDS

Partnering with Consumers
(Standard 2)

Epworth HealthCare



Underpinning our ambition are four clear strategic priorities:

Exceptional patient experience and outcomes
To empower our patients and deliver compassionate, expert and coordinated care.

A thriving healthcare organisation
To adapt and grow in a changing healthcare landscape by delivering a unique private not-for-profit healthcare organisation.

Remarkable place to work and practice
To ensure Epworth is an outstanding place to work and practice through a culture of care and investment in our people.

Digitally connected care
To innovate and improve the digital experience, interactions and outcomes for our patients, staff and doctors.

https://www.epworth.org.au/

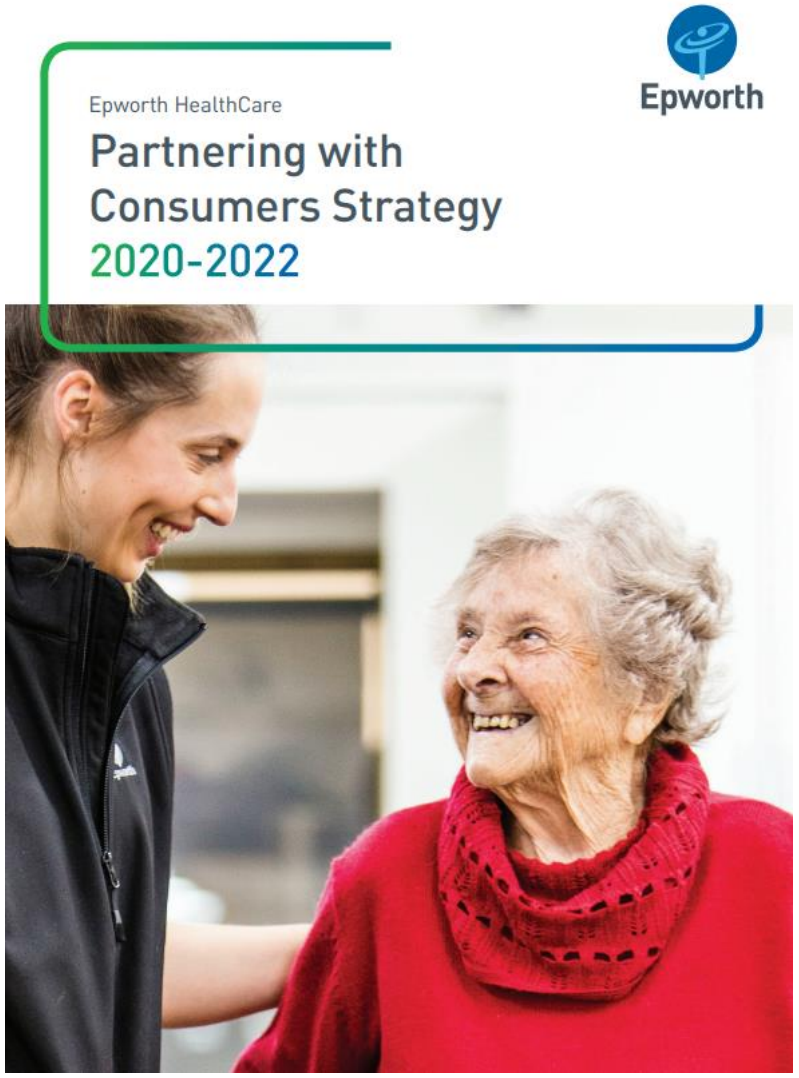
Partnering with Consumers: Developing our strategy

Epworth

Our approach included:

- Building and developing **foundations** to support effective consumer engagement
- Gaining **support** from our Board and Senior Leadership Teams
- **Co-designing** and developing resources and materials (including procedures) to support staff and consumers
- **Focusing** on **meaningful engagement** across our organisation

Partnering with Consumers Strategy



Available from: https://www.epworth.org.au/who-we-are/every-patient-matters/partnering-with-consumers/partnering-with-consumers-strategy

Implementing our strategy

Epworth

Stages

1. Awareness (‘I understand why’)
2. Desire (‘I have decided to’)
3. Knowledge (‘I know how to’)
4. Ability (‘I am able to’)
5. Reinforcement (‘I will continue to’)

Target

1. Staff who interact with patients/consumers
2. Non-consumer facing staff
3. Managers and leaders
4. Consumers – includes patients, families, carers and community members

Key messages

1. Encourage your patients to ask questions and check their understanding
2. It is everyone's role is to support our consumers to have a voice
3. If we truly listen to our consumers we are better prepared to provide the care they really need, not the care we *think* they need
4. The 5 Cs provide a framework for what we’re already doing well

Implementing our strategy

Benefits of true partnership

Effective partnership between Epworth and our patients, families and carers creates:

- more user-friendly facilities, services and models of care and
- improved systems/processes to improve the safety and quality of care.

The objective is to improve patient experience, outcomes and quality of care including:

- improved clinical outcomes, for example shorter length of stay and reduced admission rates
- improved compliance with treatment
- decreased rates of healthcare acquired infections and
- improved functional status.

Partnering with consumers

How it feels.
What it looks like.

Epworth

1. Clear communication

'I' the consumer	'I' the employee at Epworth
> I receive high quality information that I can readily understand and act on > I can easily ask questions and have conversations about my healthcare	> I actively listen to patients, their families and carers > I provide opportunities for asking and answering questions > I use plain language and check their level of understanding

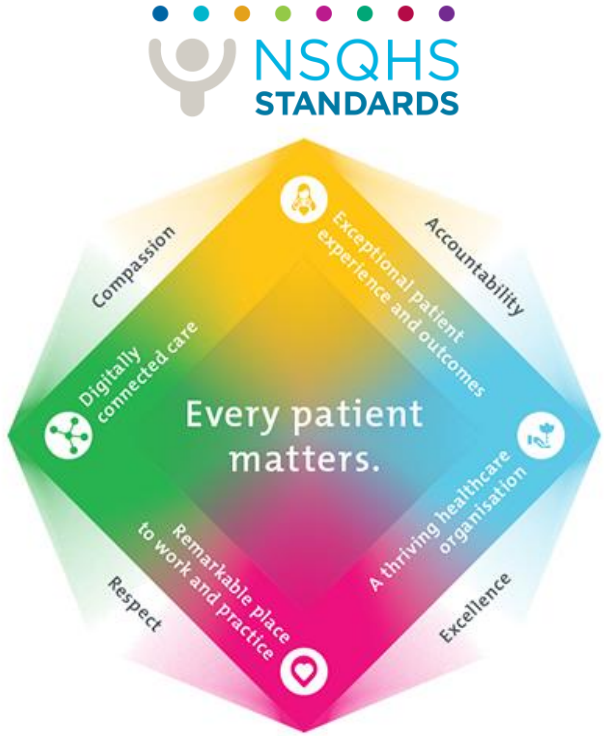
Epworth

Consumer Advisors

Members of the community that have been onboarded to a dedicated role, focusing on providing a consumer voice and partnering in various initiatives across our organisation

- ✓ Developed processes, policy documents and resources to support
- ✓ Developed a register of Consumer Advisors
- ✓ Implemented consumer members on governance committees
- ✓ Provided coaching and support to Consumer Advisors and staff to support impactful partnerships

Outcomes


NSQHS
STANDARDS
Compassion
Accountability
Exceptional patient experience and outcomes
Digitally connected care
Every patient matters.
A thriving healthcare organisation
Remarkable place to work and practice
Respect
Excellence


Epworth

Learnings

THE WHY

From LITTLE THINGS BIG THINGS Grow

Thank You

Correspondence: EHClinicalServices@epworth.org.au

Acknowledgements:

- Epworth staff, patients and Consumer Advisors
- Epworth Consumer Advisory Committee
- Epworth Medical Foundation and the generosity and support from the Maryjane Crabtree Staff Scholarship

Healthcare Excellence Canada
Excellence en santé Canada

Rewiring our Approach to Safety:

Measurement and Monitoring of Safety in Canada

Anne MacLaurin, Healthcare Excellence Canada
Maaike Asselbergs, Patient's for Patient Safety
Dr. G. Ross Baker, University of Toronto

OUR PURPOSE

To shape a future where everyone in Canada has safe and high-quality healthcare.

Healthcare Excellence Canada

Patient Engagement

We believe that everyone should have safe and high-quality healthcare.

How safe is our care?

2004 Canadian Adverse Events Study

The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada

Patient safety is receiving growing attention in Canada. Numerous legal cases and media stories have highlighted the consequences of unintended adverse events (AEs). In 2002 the Canadian government budgeted $50 million over 5 years for the creation of the

Methods

Chart review of

3745 patient charts

in 20 hospitals in 5 provinces using validated review methods

Overall AE rate of 7.5%, of which

37% judged preventable

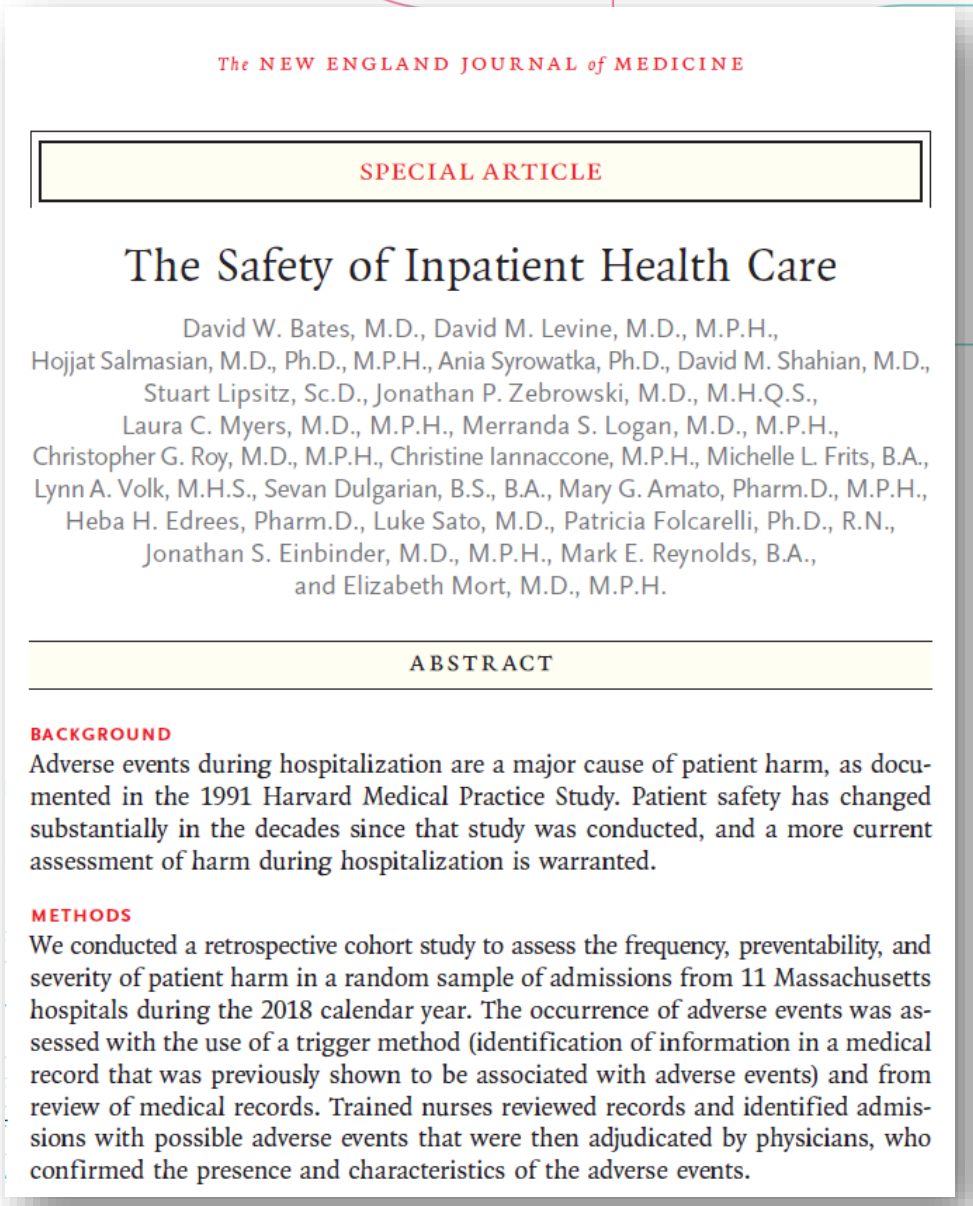
Translates to 185,000 events per year and

9250 to 23750 deaths

associated with AEs

How Safe is Inpatient Health Care Now?

- Adverse events were identified in nearly **one in four** admissions
- Approximately **one fourth of the events were preventable**.



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H., Hojjat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D., Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S., Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H., Christopher G. Roy, M.D., M.P.H., Christine Iannaccone, M.P.H., Michelle L. Frits, B.A., Lynn A. Volk, M.H.S., Sevan Dulgarian, B.S., B.A., Mary G. Amato, Pharm.D., M.P.H., Heba H. Edrees, Pharm.D., Luke Sato, M.D., Patricia Folcarelli, Ph.D., R.N., Jonathan S. Einbinder, M.D., M.P.H., Mark E. Reynolds, B.A., and Elizabeth Mort, M.D., M.P.H.

ABSTRACT

BACKGROUND

Adverse events during hospitalization are a major cause of patient harm, as documented in the 1991 Harvard Medical Practice Study. Patient safety has changed substantially in the decades since that study was conducted, and a more current assessment of harm during hospitalization is warranted.

METHODS

We conducted a retrospective cohort study to assess the frequency, preventability, and severity of patient harm in a random sample of admissions from 11 Massachusetts hospitals during the 2018 calendar year. The occurrence of adverse events was assessed with the use of a trigger method (identification of information in a medical record that was previously shown to be associated with adverse events) and from review of medical records. Trained nurses reviewed records and identified admissions with possible adverse events that were then adjudicated by physicians, who confirmed the presence and characteristics of the adverse events.

The Magnitude of Unintended Patient Harm

Patient harm in Canadian hospitals? It does happen.

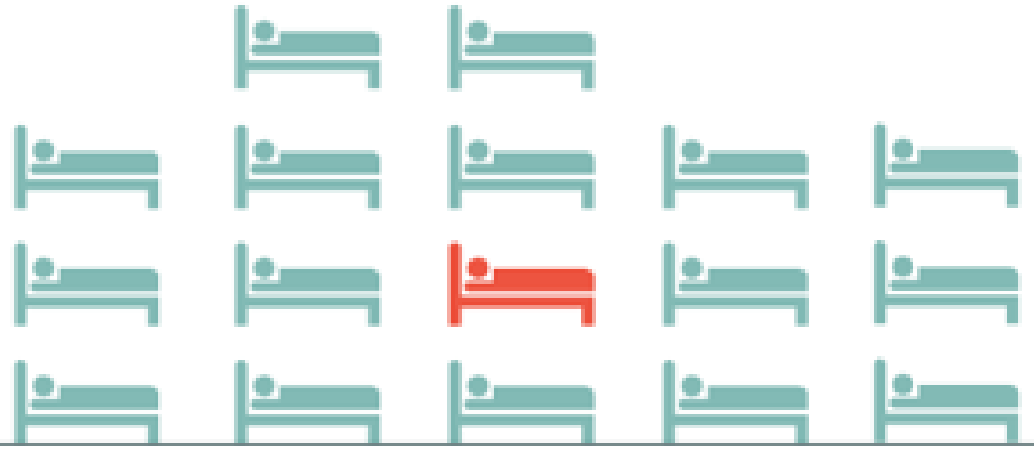
Hospitals are generally safe, but sometimes harmful events happen that affect patients. Many of these events are preventable.

How often does it happen?

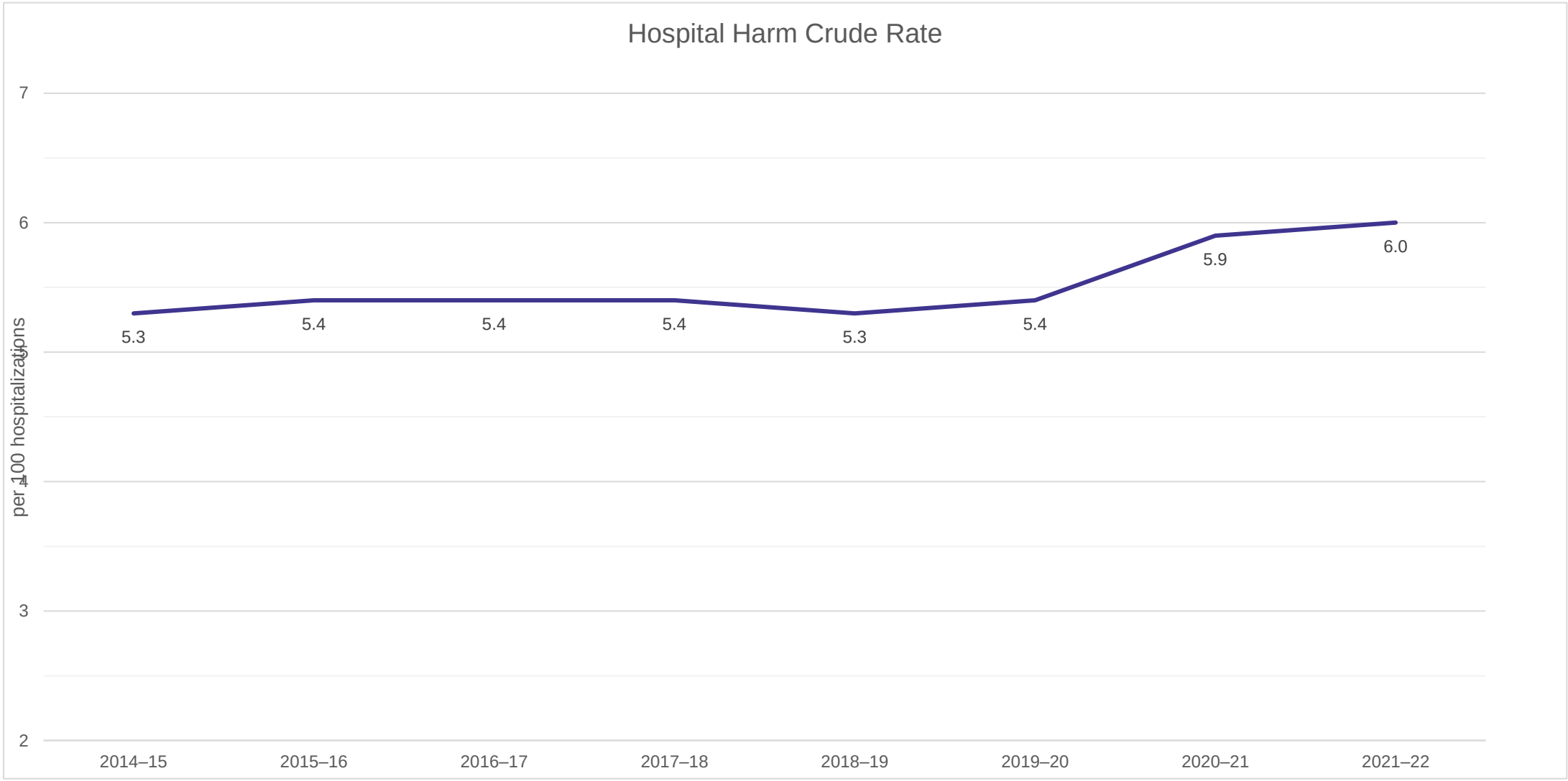
In 2021–2022,

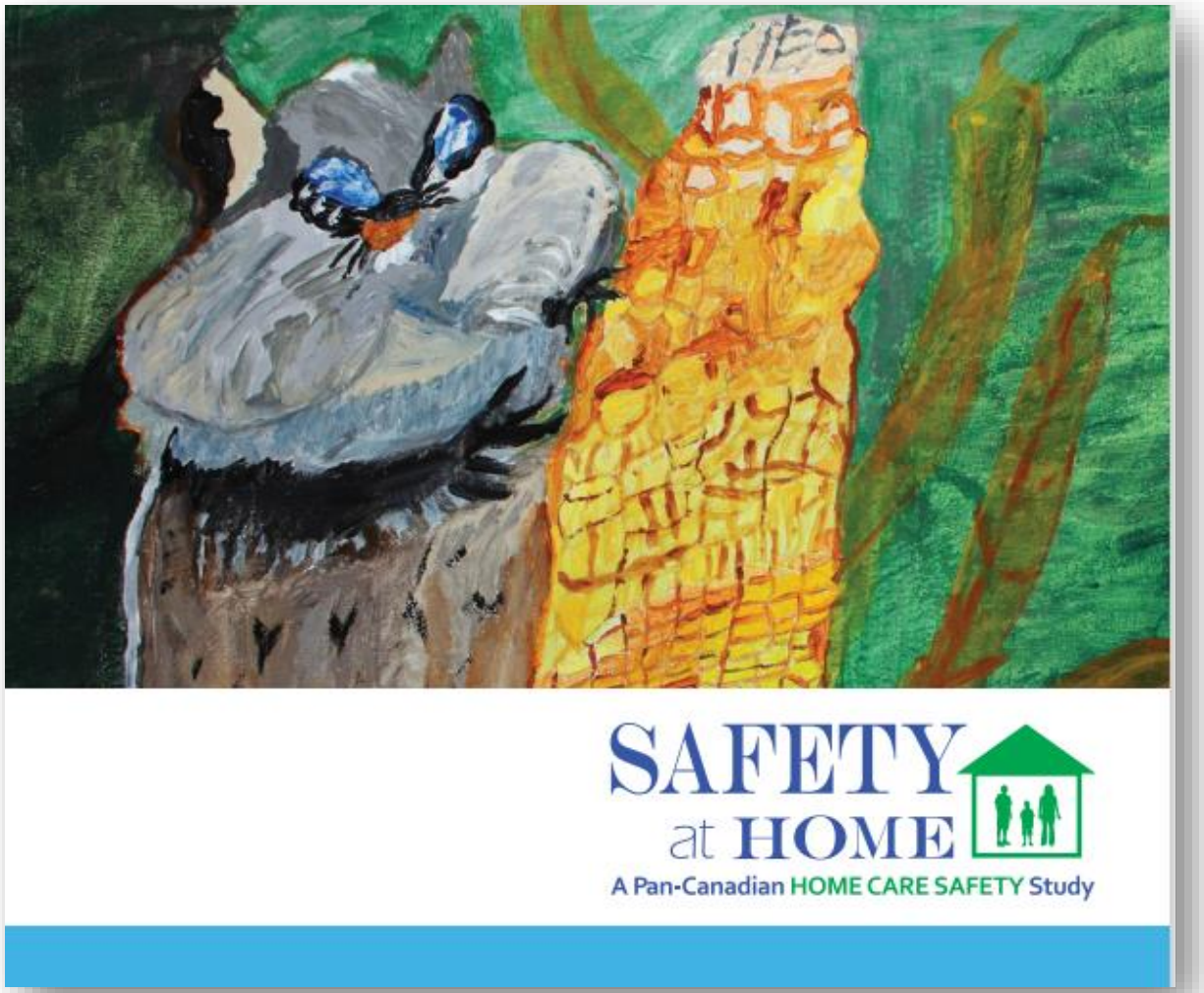
1 in 17 hospital stays

in Canada involved at least one harmful event (140,000 out of 2.4 million hospital stays).



Hospital Harm Rate is Increasing





Blais, Sears, Doran, Baker, et al., 2013

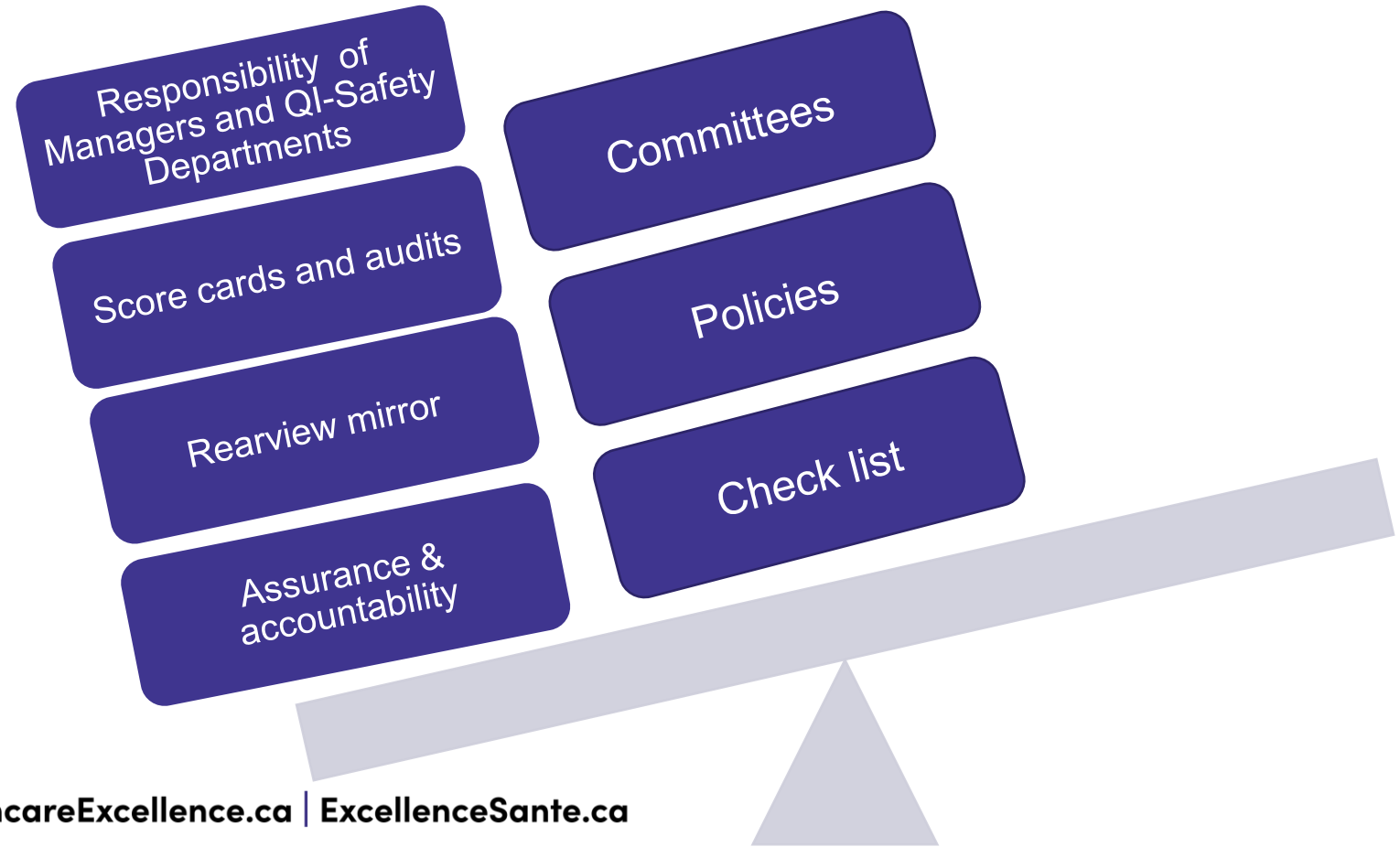
- 2008/2009 Review of Canadian home care charts indicates that **13% of home care clients experienced unintended harm**
- Delirium, sepsis and medication-related harms are associated with an **increased risk of client death**

Typical approach to preventing harm in healthcare

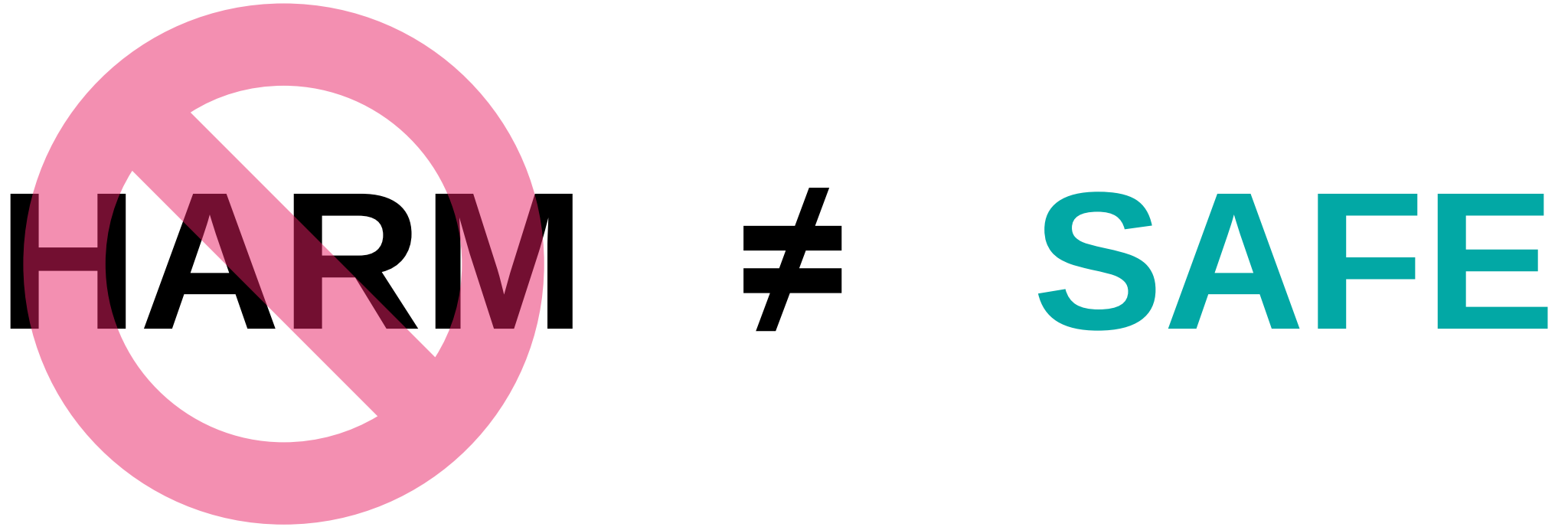
What are the common and current approaches and strategies used in your organization for addressing harm and improving safety?

On a scale of 0-10, how effective are your strategies at reducing harm and improving safety?

Preventing Harm



The absence of harm is not the same as the presence of safety



Do measures of harm tell you how SAFE your care is or how LUCKY you have been?

Reflection and Sharing

- Do measures of harm tell you how safe your care is OR how Lucky you have been?
- Can you think of a time when you needed to rely on luck in the absence of safety?

An introduction to a new approach to safety!

Video

https://www.youtube.com/watch?v=8CmOjh7gqTY

The measurement and monitoring of safety framework

A short introduction by Professor Charles Vincent

Expanded and shared understanding of “what is safety”

Preventing Harm

- Patient safety projects
- Audits
- Responsibility of Managers and QI-Safety Departments
- Score cards and numbers
- Rearview mirror
- Assurance & accountability

Creating Safety

- Everyone has a role
- Listening, observing and perceiving
- Proactive
- Curiosity & Inquiry
- A way of thinking, acting, responding
- Coaching

Key learnings from the MMSF Collaborative in Canada

1

Changes the way we think about safety. The focus moves away from past harm to a more holistic and proactive view of safety. Provides a shared and consistent understanding of safety.

2

Moves us from assurance and accountability reporting to a “practice of inquiry”

3

Empowers everyone to take a proactive role in safety. Safety can be created.

4

Promotes the value that patients and care partners have in creating safety

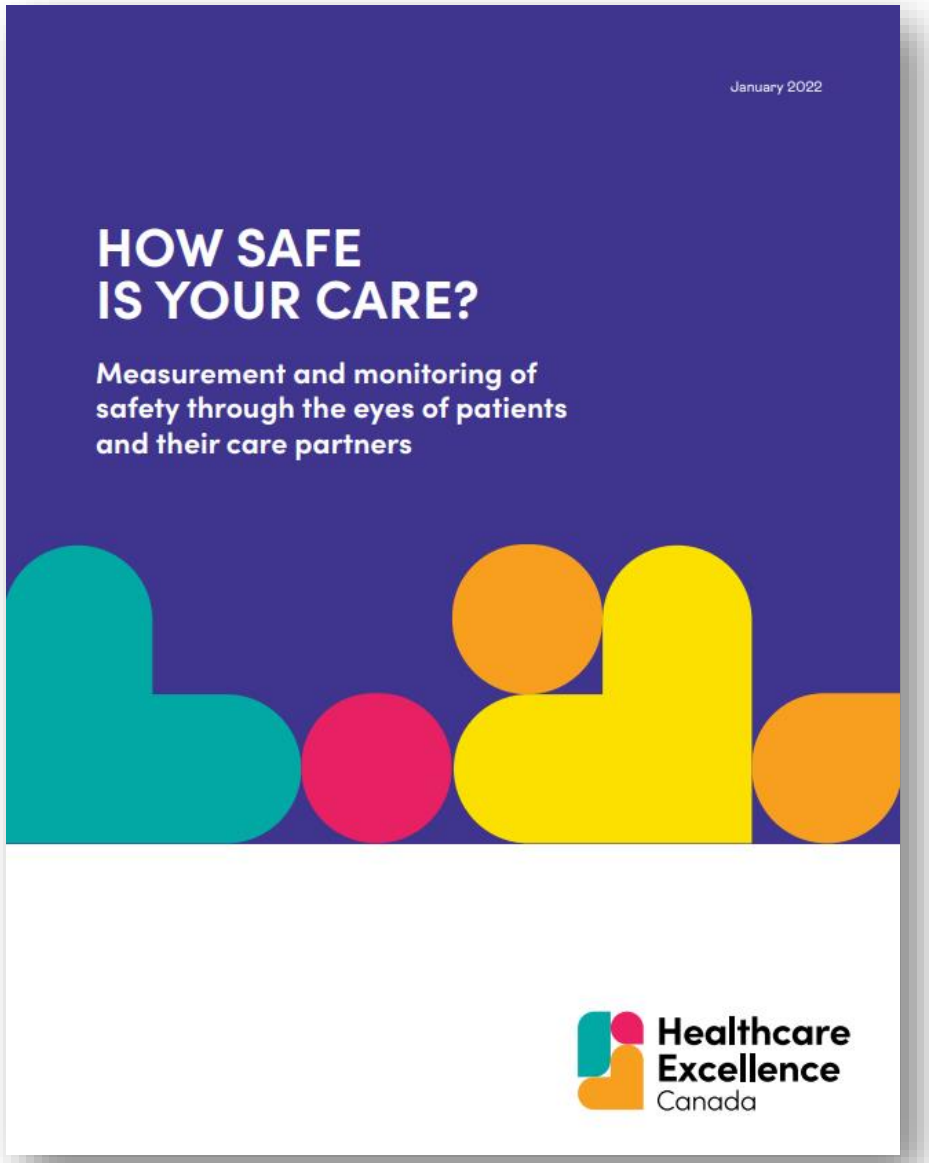
Building capacity for patient safety in partnership with patients

What we learned:

1. Patients are an essential but all too often an underused defense in preventing patient harm.

2. Healthcare providers have a really hard time talking to patients and care partners about patient safety.

3. Healthcare providers and patients' perspectives about safety often differ.



Available on the HEC website under the Presence of Safety webpage.

[How Safe is Your Care? (healthcareexcellence.ca)]

Drs. Lianne Jeffs, Kerry Kuluski, and G. Ross Baker, and Maaike Asselbergs, Anne MacLaurin and Virginia Flintoft

What patients told us about safety

The Measurement and Monitoring of Safety Framework


Past harm
Has patient care been safe in the past?
Integration & learning
Are we responding and improving?
Safety measurement & monitoring
Reliability
Are our clinical systems & processes reliable?
Anticipation & preparedness
Will care be safe in the future?
Sensitivity to operations
Is care safe today?

Past Harm -
Has care been safe in the past?

- Reporting and responding to harm.
- While this is very important, measures of harm on its own is not enough

Widening our view of harm

Physical harms
(treatment-specific & general harm)

Psychological harm

Harms in the transition of care

Over-treatment

Under-treatment

Delayed or inadequate diagnosis

Dehumanisation

What patients and care partners tell us about harm


Past harm
Has patient care been safe in the past?
Integration & learning
Are we responding and improving?
Safety measurement & monitoring
Reliability
Are our clinical systems & processes reliable?
Anticipation & preparedness
Will care be safe in the future?
Sensitivity to operations
Is care safe today?

Measuring to Assess if our Clinical Systems and Processes are Reliable

"Gauging the probability that a task, process, intervention, or pathway will be carried out or followed as specified."

What would happen if we had a system of only measuring the number of people who fell through the ice rather than measuring the thickness of the ice?

What Patients told us about Reliability


Past harm
Has patient care been safe in the past?
Integration & learning
Are we responding and improving?
Safety measurement & monitoring
Reliability
Are our clinical systems & processes reliable?
Anticipation & preparedness
Will care be safe in the future?
Sensitivity to operations
Is care safe today?

Seeing

Hearing

Perceiving

… and Acting on the information gathered

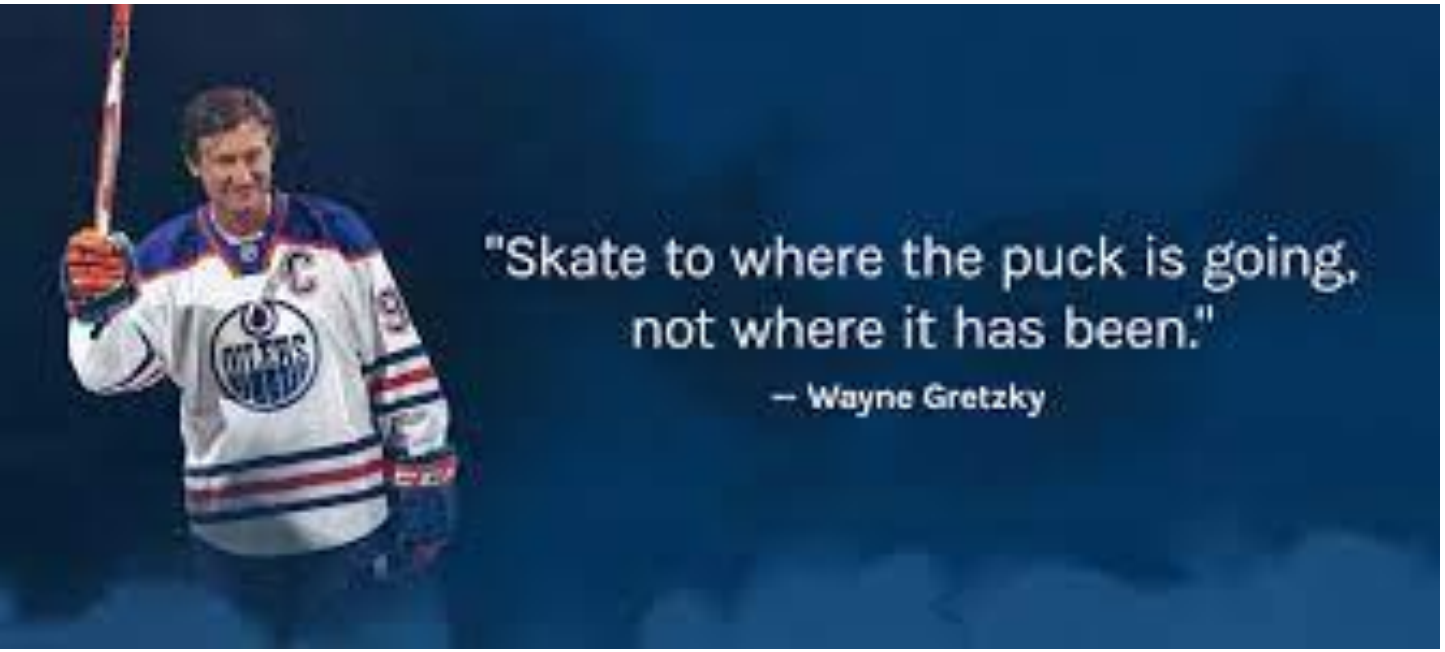
Sensitivity to Operations: Is care safe today?

HealthcareExcellence.ca | ExcellenceSante.ca

What patients and care partners told us about sensitivity to operations


Past harm
Has patient care been safe in the past?
Integration & learning
Are we responding and improving?
Safety measurement & monitoring
Reliability
Are our clinical systems & processes reliable?
Anticipation & preparedness
Will care be safe in the future?
Sensitivity to operations
Is care safe today?

Anticipation and Preparedness - Will care be safe in the future?



- *Focus on identifying possible sources of future harm and working toward becoming more resilient to them."*
- *Don't wait for things to go wrong before trying to improve safety*

What Patients told us about Anticipation and preparedness


Past harm
Has patient care been safe in the past?
Reliability
Are our clinical systems & processes reliable?
Sensitivity to operations
Is care safe today?
Anticipation & preparedness
Will care be safe in the future?
Integration & learning
Are we responding and improving?
Safety measurement & monitoring

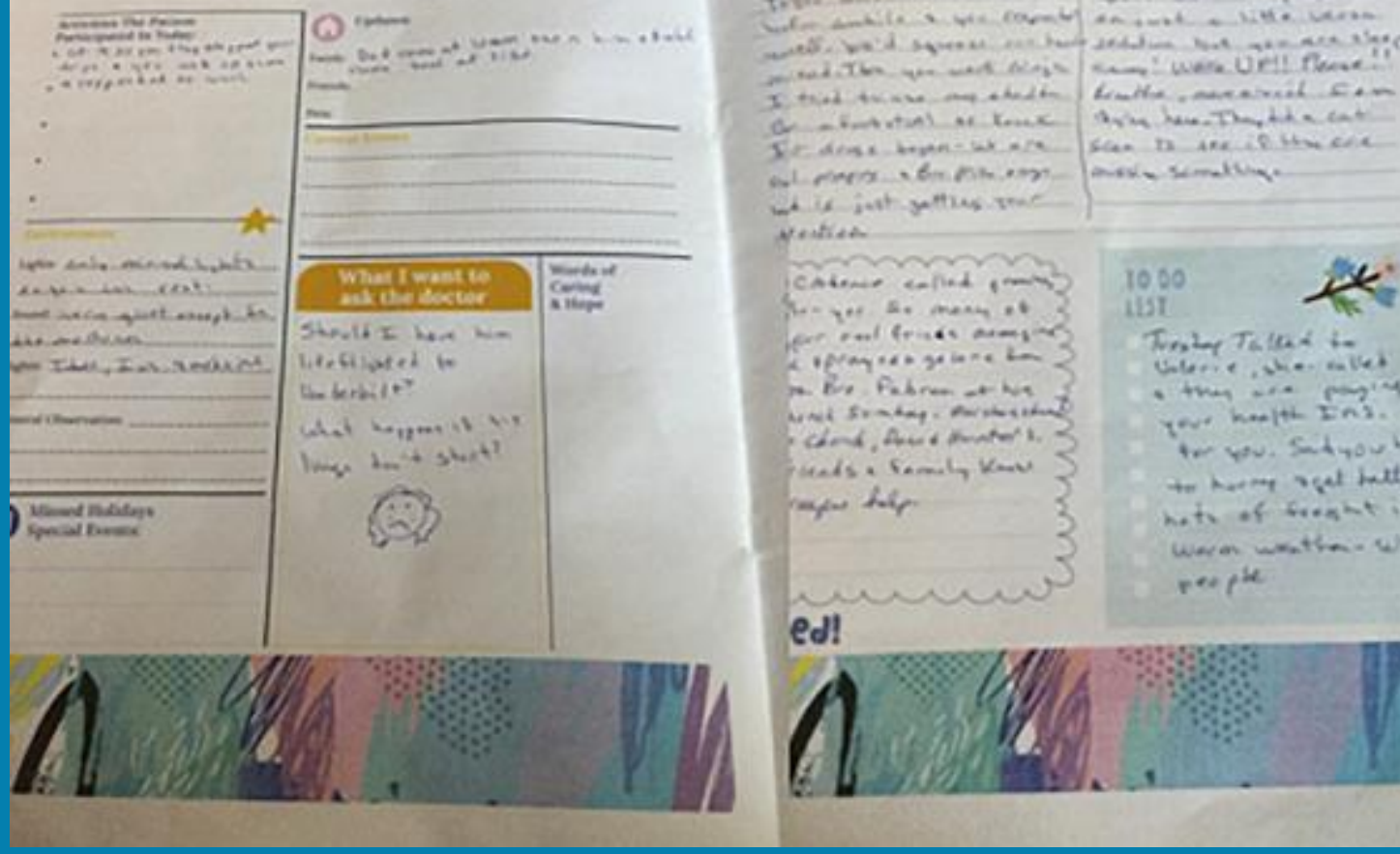
Integration and Learning: Are we responding and improving?

- The development of systems to promote a cycle of learning and sharing from safety incidents, multiple sources of safety intelligence and insights developed through the other domains.”

Please don’t let this become the lost piece of the puzzle.

A learning system is a safe system!

Expanded and shared understanding of “what is safety”



What patients and care partners told us about Integration and Learning

Expanding your thinking on safety

“The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking.”

Albert Einstein

Questions

.

Resources:

- Presence of Safety
  - Presence of Safety (healthcareexcellence.ca)
- Measurement and monitoring of safety through the eyes of patients and their care partners
  - https://www.healthcareexcellence.ca/media/dnrgw10m/20220525_howsafeisyourcare_final_en.pdf