Does patient engagement in patient safety and quality committees advance safe care or is it a myth?

February 24, 2016
Your line will be muted until the session begins.
Interacting in WebEx

Click the hand up icon to ask your question or make a comment live (your line will be unmuted)

Note: feature not available for mobile device users

Type your question or comment here (select “all participants” from the drop-down menu)
Stay Tuned!

We’ll get started in just a few moments!
Does patient engagement in patient safety and quality committees advance safe care or is it a myth?

February 24, 2016
Introductions

Virtual conference room:

- Chat
- Mute/unmute
- Hand up
  (not for mobile devices)

Getting to know each other:

- City
- Country
- Role
Your Questions

- Emerging evidence, success stories, struggles
- How can patients contribute
- How to select & prepare patients
- How do we prepare the committee
- How do we evaluate the impact

- Patient engagement: models, initiatives, examples
- Patient and family centred care: shared decisions
<table>
<thead>
<tr>
<th>Welcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging Patients and Families to Improve Quality and Safety – <strong>Malori Keller</strong></td>
</tr>
<tr>
<td>Q&amp;A/ Discussion</td>
</tr>
<tr>
<td>Patient Safety and Quality Committees in Low and Middle Income Settings - <strong>Alethse De la Torre Rosas</strong></td>
</tr>
<tr>
<td>Q&amp;A/ Discussion</td>
</tr>
<tr>
<td>Group discussion</td>
</tr>
<tr>
<td>Wrap up, evaluation</td>
</tr>
</tbody>
</table>
Theresa Malloy Miller

Moderator

Member Patients for Patient Safety Canada
Engaging Patients & Families to Improve Quality & Safety

Malori Keller
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Engaging Patients & Families

• Patient-and family-centred care seeks to create partnerships between patients, families, staff and physicians to promote:
  – Respect & dignity
  – Collaboration
  – Information sharing
  – Meaningful participation

www.ipfcc.org
Three Levels of Engagement

• Direct Care
  – *Open Family Presence*
  – Interdisciplinary Rounds at the Bedside
  – Whiteboards

• Organization
  – PFCC Steering Committees
  – *Quality & Safety Committees*
  – Quality Improvement Teams

• System
  – *Safety Alert System/ Stop the Line*
  – Patient portal

http://content.healthaffairs.org/content/32/2/223.abstract
Direct Care Level: Open Family Presence

“Isolating patients at their most vulnerable times from the people who know them best can place them at risk for adverse events, emotional harm and inconsistent care”

(Maureen O’Neil, President, Canadian Foundation of Healthcare Improvement http://www.cfhi-fcass.ca)
CFHI: 5 Reasons to Take the Better Together Pledge

1. Better Coordination of Care
2. Fewer Medication Errors
3. Fewer Falls
4. Fewer 30 Day Readmissions
5. Better Patient and Family Experience

http://www.cfhi-fcass.ca/WhatWeDo/better-together/pledge
Organization Level

• Quality & Safety Committees
  • Cypress Health Region
  • 4 advisors on committee
  • Review staff and patient incident reports including root cause analysis

• Quality Improvement Events
  • All Health Regions in SK
  • Minimum of 1 advisor on every Rapid Process Improvement Workshop
  • Advisor is a full participant on the team to co-design processes

Examples available at: www.betterhealthcare.ca
System Level

• Safety Alert System/ Stop the Line
  • Provincial & regional initiative
  • 2 advisors on provincial steering committee
  • 8 advisors on working group focused on engaging patients and families in reporting

• The Safety Alert/Stop the Line initiative encompasses processes, policies, and behavioural expectations that support patients, staff, and physicians to be safety inspectors, to identify and fix potentially harmful mistakes in the moment, or to stop the line and call for additional help to restore safety.

http://hqc.sk.ca/improve-health-care-quality/safety-alert-stop-the-line/
Keys to Successful Engagement

• Leadership commitment to PFCC and patient engagement is vital as it takes time to engage and to create partnerships.

• Recruitment includes two-way interview

• Patient and Family Advisor Orientation

• On-going mentorship
  • PFCC leads -- staff liaison
  • Online forum for Patient/Family Advisors to share their learnings and to network.
“Feeling safe is knowing that no harm will come. Each and every encounter with a health care worker regardless of where they work or what their job is important. Acknowledging me and my family member with a simple hello really says a lot. Taking the time to listen to me or my family member is also very important. You may not have the answers and that is okay but being open and honest with me is very important. Tell me what you know and how you can help. And if you cannot please be open and point me to where I need to go. You will not always have all the answers. I know that your time is limited but don’t ignore me and don’t rush me. Engage me. Educate me. Hear my voice. Explain to me as best you can what your role will be in helping me. How long it will take. Where I need to go. How to get there. What to expect. The more I know the safer I will feel.”

(Brenda Andres, Family advisor, Cypress Health Region.)
Does patient engagement in patient safety and quality committees advance safe care or is it a myth?
Discussion
Patient Safety and Quality Committees in Low and Middle Income Settings

Alethse De la Torre Rosas
Overview

- The context of Patient Safety and Quality Committees in low and middle income countries.
- The gap between creation and implementation of Safety and Quality policies.
- The social context and the imbalance of power: a barrier for patient engagement.
Context of the challenges faced in Low and Middle Income Countries

Social

- Levels of literacy, inequality and bureaucracy
- Language and common beliefs
- Vulnerable populations

Healthcare System

- Severe healthcare worker shortages
- Uncoordinated and fragmented
- Centralized and difficult to access

Surveillance and Data

- Not registered, reliable or public
- Scarce published information for policy makers
Case Study - Mexico

Official National Regulation

Infection Control and Prevention committees

Monthly meetings

Report their surveillance results to the National System

About

Gap

Barriers

Reduction of healthcare associated infections

Are there really zero infections?
Mexican National Survey, 2012

Evaluate the rate of Healthcare associated infections (HCAI) in hospitalized patients

53 hospitals

Evaluation of Infection Control and Prevention Committees and National regulations implemened

Establish the rate of Healthcare associated infections (HCAI) in hospitalized patients
Challenges to the Committee’s function - Surveillance and Data-

**Scarce personnel**
- Not all events were registered.

**Multiple reports**
- Personnel overwhelmed.

**Lack of training and recognition**
- Different interpretation of what was required.

Information biased and unreliable for policy makers + Redundant work + Unsatisfied Personnel
Challenges to the Committee’s function
- System Structure-

Hierarchical

- Low attendance rate.
- No inclusion of patients.

Information discussed

- Not available for the general public and sometimes for healthcare workers.

Status quo
Slow/ No improvement
Consequences of Poor Implementation
The Importance of Patient Engagement for Policy Implementation

POLICY
To engage patients in the surveillance of the hospital hand hygiene program

“Plan”
“Do”
“Act”
“Study”

About
Gap
Barriers
The Importance of Patient Engagement for Policy Implementation

- All patients and healthcare workers were “trained on the importance of hand hygiene” and invited to participate.
- Availability of resources was checked every day.

“Plan”

“Act”

“Do”

“Study”

“Do”

“Study”
The Importance of Patient Engagement for Policy Implementation

"Plan" -> "Study" -> "Act" -> "Do" -> "Plan"

No change in the adherence!

Survey: 150 patients
- ALL received information
- ALL had resources available (alcohol gel hand rub and posters)

40% identified at least one opportunity missed by HCW to perform hand hygiene.

NO PATIENT asked the HCW to sanitize their hands before their contact.
Imbalance of Power

- They are the professionals they know
- I am embarrassed to point out their errors
- I haven’t been invited to participate
- The information is very technical
- I didn’t know
- If I say something they will be angry or stop my treatment
- I have no time or money to participate

About Gap Barriers
Where to start for Patient Engagement?
-Stop the Power Imbalance-

Committees flexible with reliable data
Facilitate patient participation
Patient inclusion – Invitation
Open door policy for patients
Ask for patient’s feedback
Health literacy

Raise Healthcare workers awareness of patient safety
Positive Results Through Comprehensive Engagement

- Social worker
- Rheumatologist
- Orthopaedist
- Anaesthesiologist
- Equipment supplier
- Infection control Nurse

1 week before surgery
- Infectious diseases specialist
- Infection control Nurse

Day before surgery
Patient hospitalized
- Internal medicine specialist
- Nurses
- Infection control nurse

During surgery
- Orthopaedist
- Nurses
- Anaesthesiologist
- Infection control nurse

After surgery
Patient hospitalized
- Internal medicine specialist
- Orthopaedist
- Anaesthesiologist
- Physiotherapy
- Nurses
- Infection control nurse

After patient discharge and up to one year
- Rheumatologist
- Orthopaedist
- Infection control nurse

Checklist

Infection Rate per 100 surgeries

Year

2008  2009  2010  2011  2012  2013  2014

30
25
20
15
10
5
0

Every patient safe  La sécurité pour tous les patients  www.patientsforpatientsafety.ca  www.securitepatients.ca
Conclusions

• Aside from the patient safety policy itself - it is the structure of the healthcare system and the involvement of the patient that determines policy success:
  – Without proper committee structure gaps emerge between creation and implementation of patient safety policies.
  – Without the involvement of the patient there is no independent check that policies are properly embedded.

• Work together: patients are essential actors to redirect the implementation of policies.

• Middle and low income countries can NOT AFFORD to delay practices that improve the safety of patients.
Discussion
Resources


• Ontario Hospital Association. Governance Toolkit.
  Section 1.4. Quality Committee Terms of Reference.
  Section 1.5. Recommendations for an Effective Quality Committee.

• Agency for Healthcare Research and Quality. Guide to Patient and Family Engagement in Hospital Quality and Safety.

• Proceedings from past webinars:
  Tips for Partnering with Patients and Families on Committees.
  How can we make the partnership with patients and families more impactful?
  Learning from the best: A webinar with the Patient Safety Champion Awards Finalists

• Health Quality Council Saskatchewan
  www.hqc.sk.ca and http://blog.hqc.sk.ca/
Wrap up, Evaluation, Next Steps

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Thank You

Mulțumesc

Obrigado

Так

Asante

Grazie

Dhanyaawaad

Танкер

Shukran

Thank

Mahalo

Kiitos

Toda

Shukria

Gracias

Merci

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