IMPROVING CARE TRANSITIONS
Among Multiple Care Providers In Rural Areas

November 9, 2018
Our Mission

• Engage and inspire health care providers
• Create safe cultures
• Create reliable systems of care
• Prevent patient harm in Indiana

We partner under the key principle that we don’t compete on patient safety

A State of Mind
Painting created by Regina Holliday during the 2018 Indiana Patient Safety Summit
OUR MISSION

REDUCING PREVENTABLE HARM

OUR VALUES

• Integrity
• Culture of Patient Safety
• Excellence
• Advocacy
WELCOME

• Project Review
• Case Example/Story
• Communication & LTC
• Communication & EMS
• Communication/Culture & Survey
• Summary
PROJECT OVERVIEW AND OBJECTIVES

• Provide training and tools for hospitals, long-term care organizations, emergency medical services that support the transition of high risk patients, especially those with chronic diseases such as COPD
• Increase knowledge of shared accountability/Just Culture
• Develop and share communication tools and techniques
ACTIVITIES

• *Problem Identification Webinar* - November
• *Communication Webinar* – December
• *In-Person Patient Safety Forums* - January
• *Identify community members as potential partners*
  – Skilled nursing facilities that you discharge to frequently
  – Inbound and outbound EMS agencies you interact with.
The single biggest problem in communication is the illusion that it has taken place.

-George Bernard Shaw
Communication Process

SEND MESSAGE
COMMUNICATION CHANNEL
FEEDBACK

Who
What
When
Where
Why
How
How Much
TRANSITION STORY TAKEAWAYS

- Nursing Home
- EMS & Hospital
- Emergency Dept.
- EMS & N. Home
- Floor
- ICU

IHAconnect.org/Quality-Patient-Safety
PA/LTC CHALLENGES

Module 1.
Detecting Change in a Resident's Condition

Improving Patient Safety in Long-Term Care Facilities

IHAconnect.org/Quality-Patient-Safety
CHRONIC VS. EMERGENT

- Hospital Transfers: Probably an emergent situation (vs. return to LTC)
- Focus has been on avoiding hospitalization
NATURE OF LTC COMMUNICATION

• Chart may or may not reflect changes or clinical evaluation of changes
  – Nurse onsite?
  – Physician offsite.
  – Does staff even know of diagnosis or specific concerns?
### Long-Term Care Handoff Communication

**From**
- □ SNF
- □ ICF
- □ RCF/ALF
- □ Swing Bed
- □ Rehab
- □ LTCH
- □ Group Home
- □ Other _______________________

**LTC Center**

**Address**

**Phone**

**Fax**

**Resident’s Physician** □ Notified

**Physician Phone**

**Resident Name (Last, First, MI)**

**Date of Birth**

**Sex**

**Social Security Number**

**Reason for Transfer**
- □ Altered Mental Status
- □ Shortness of Breath
- □ Hyper/Hypoglycemia
- □ Fever
- □ Chest Pain
- □ Abdominal Pain
- □ Weakness
- □ Other _______________________
- □ Injury/Fall (Describe) _______________________
- □ Date/Time Onset/Injury _______________________

**CODE STATUS**
- □ See DNR Form
- □ Full
- □ Limited
- □ DNR

**ALLERGIES**
- □ No Known Allergies
- □ See MAR

**Durable Power of Attorney for Health Care**

**Guardian**

**Name**

**Phone**

**Advance Directives** □ Yes □ No

**Resident able to make own decisions** □ Yes □ No

**Speaks English** □ Yes □ No □ If no, specify _______________________

**Religious/Literacy Concerns** □ None

**Admissions to Hospitals/Other Facilities in Past Month**

**Chronic Conditions** □ See Diagnosis Sheet

**Immunizations**
- □ None
- □ Influenza ___/___
- □ Pneumonia ___/___
- □ Tetanus ___/___
- □ TB Skin Test ___/___

**CHECK ALL THAT APPLY**

---

[Link to website: IHAconnect.org/Quality-Patient-Safety]
TWO-STEP PROBLEM

EMS (safe transport) and Hospital (treatment)
BARRIERS

• Meeting needs of next providers
• Overcoming location issues
• Bringing right people together to gather and process information
• What pathway?
INFORMATION EXCHANGE

Information Exchange

WE HAVE PROBLEMS EXCHANGING INFORMATION WITH:
• Hospitals
• Dispatching Service
• Long-term Care Facilities

EMS CULTURE OF PATIENT SAFETY
TOP PRIORITIES BY DIMENSION
SURVEY RESULTS FOR CPS EMS Rollup

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>2018 Priority Rank</th>
<th>2018</th>
<th>QUESTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Exchange</td>
<td>1st</td>
<td>33.3%</td>
<td>We have problems exchanging information with Hospitals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>We have problems exchanging information with Dispatching Service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>We have problems exchanging information with Long-term Care Facilities.</td>
</tr>
<tr>
<td>Staffing, Work Pressure and Pace</td>
<td>2nd</td>
<td>41.3%</td>
<td>Tiredness impacts our service’s job performance.</td>
</tr>
<tr>
<td>Communication Openness</td>
<td>3rd</td>
<td>47.0%</td>
<td>It is difficult to voice disagreement in this service.</td>
</tr>
</tbody>
</table>
Clinical handover of patients arriving by ambulance to a hospital emergency department: A qualitative study

Nerolie Bos ML, RN (Research Nurse)\textsuperscript{a}Julia Crilly PhD, RN (Associate Professor, Nurse Researcher)\textsuperscript{a}Elizabeth Patterson PhD, RN (Professor, Head)\textsuperscript{b}Wendy Chaboyer PhD, RN (Professor, Director)\textsuperscript{c}

“Quality of handover appears to be dependent on the personnel’s expectations, prior experience, workload and working relationships. Lack of active listening and access to written information were identified issues.”

Optimizing the Patient Handoff Between EMS and the Emergency Department

Zachary F. Meisel, MD, MPH*; Judy A. Shea, PhD; Nicholas J. Peacock, DO; Edward T. Dickinson, MD; Breah Paciotti, MPH; Roma Bhatia, BA; Egor Buharin; Carolyn C. Cannuscio, ScD

Corresponding Author, E-mail: zfm@upenn.edu, Twitter: @zacharymeisel.

“They identified the handoff as a critical, brief window (or ‘golden minute’) in which they could influence the course of their patients hospital-based care.”

https://www.annemergmed.com/article/S0196-0644(14)00597-6/fulltext
COMMUNICATION BARRIERS

• Unclear expectations
• Time compression
• Confusing factors
• Authority gradients
• Interdisciplinary strain
• Critical information requiring a decision
• Competing technology - Phone, Text, Pagers
A positive safety culture is expected to result in **decreased risk, fewer errors, adverse events** and other negative safety outcomes.
WHAT IS THE PROBLEM?

• Healthcare has been punitive.
• Employees are afraid to speak up if they make a mistake or have a near miss or there is an unsafe condition.
• How can you fix it if you don’t know about it?
...AND THAT IS WHY WE LIFT ON THREE...
WE DID THIS?
I GUESS WE HAVE NO CHOICE BUT TO...

OPERATE?

NO. WAIT AND HOPE THINGS IMPROVE.

MEDICAL ERRORS
EMBEDDING PATIENT SAFETY

- **Prevent** errors
- **Learn** from errors that occur
- **Build** on a culture of safety

IHACconnect.org/Quality-Patient-Safety
WHAT IS PATIENT SAFETY CULTURE?

• Employees’ beliefs drive their behaviors
• If shortcuts are tolerated, they become the norm
• A punitive environment discourages open communication
• If leadership does not prioritize patient safety, no one will
ASSESSING YOUR CULTURE

- Who
- What
- How
- When
- Where
ANALYZING YOUR DATA

- Understand it
- Filter it
- Compare it
PLANNING ACTION

- Goals
- Planned initiatives
- Resources
- Process and outcome measures
- Timelines

*If you fail to plan, then you plan to fail.*
SUMMARY

• *Communication, Communication, Communication*
• *Leadership*
• *Teamwork*
• *Culture*
• *Measure*
QUESTIONS
CPS SAFETY TEAM

KATHY WIRE
JD, MBA, CPHRM, CPPS
Project Manager

ALEX CHRISTGEN
CPHS, CPHQ
Executive Director

EUNICE HALVERSON
MA, CPPS
Patient Safety Specialist

TINA HILMAS
RN, BSN, MS, CPPS
Assistant Director

LEE VARNER
MSEMS, EMT-P, CPPS
Patient Safety Director

AMY VOGELSMEIER
PhD, RN, FAAN
Patient Safety Researcher/Analyst

NOT PICTURED
JENNIFER LUX, Office/Program Manager
SHELBY COX, Patient Safety Coordinator
AIMEE TERRELL, Office Coordinator
AMANDA TEEL, Marketing Representative
CPS PROJECT LEADERS

TINA HILMAS RN BSN MS CPPS
thilmas@centerforpatientsafety.org

KATHY WIRE JD MBA CPHRM CPPS
kwire@centerforpatientsafety.org
QUALITY AND PATIENT SAFETY TEAM

Becky Hancock
Patient Safety & Quality Advisor
317-423-7799
rhancock@IHAconnect.org

Annette Handy
Clinical Director, Quality and Patient Safety
317-423-7795
ahandy@IHAconnect.org

Karin Kennedy
Vice President, Quality and Patient Safety
317-423-7737
kkennedy@IHAconnect.org

Patrick Nielsen
Patient Safety Data Analyst
317-423-7740
pnielsen@IHAconnect.org

Madeline Wilson
Patient Safety & Quality Advisor
317-974-1407
mwilson@IHAconnect.org

Rachel Kimmel
Tobacco Prevention & Cessation Quality Advisor
317-423-7728
rkimmel@IHAconnect.org

Casey Hutchens
Patient Safety Project Coordinator
317-974-1457
chutchens@IHAconnect.org

Kim Radant
Consultant, Special Projects
kradant@IHAconnect.org

Shelby Hornback
Patient Safety Intern
shornback@IHAconnect.org