Academic-Service Partnerships
to Advance Patient Safety & Quality

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University of San Francisco
Session Objectives

• Identify the elements of an effective academic-service partnership to promote accountabilities for patient safety & enhanced team communication

• Review student outcomes resulting from a partnership & the impact on student competencies for advocacy of safety & quality outcomes
The complexity of patient care
Interdisciplinary Practice
"I know the names of all the personnel that I worked with during my last shift"

Percentage of respondents who agreed:

- Physicians: 19.4%
- Technicians: 45%
- RNs: 83.3%

Leonard et al. (2006)
Teamwork

Over time, systems have migrated to a teamwork model, where quality and success are based on the team, not just the individual!

Institute for Healthcare Improvement
Paradigm Shift . . .

From the INDIVIDUAL

Single focus: clinical skills
Individual performance
Under-informed decision-making
Loose concept of teamwork
Unbalanced workload
Having information
Self-advocacy
Self-improvement
Individual efficiency

To GROUPS

Dual: clinical & team skills
Team performance
Informed decision-making
Understanding of teamwork
Managed workload
Sharing information
Mutual support
Team improvement
Team efficiency

(TeamSTEPPS)
IOM Vision Statement
Health Professions (2003)

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics.

Greiner & Knebel (2003)
Driving Forces for Partnership

- Ensure nursing students have formative opportunities to develop the KSAs to serve as advocates for patient safety & quality care outcomes

- Align agency safety & quality initiatives with our school’s student outcome competencies & strategies for clinical instruction

- Provide experiential learning to develop effective team behaviors
Imagine you are a nurse who has been given a set of new safety tools that warns you whenever your patients are in danger. That would be powerful, life-saving information, right? But what if nobody listened to you or heeded your warnings? This kind of breakdown is happening in hospitals every day. The quote below is one of 681 collected in the course of this research.

“I think nearly every day we are faced with the hand-off allergy list. Frequently, the surgeons will order an antibiotic the patient is allergic to according to the safety checklist. When the patient is out of surgery, nurses have to call the surgeon, the anesthesiologist, and sometimes even the pharmacist before someone listens. Sometimes, we go ahead and give the drugs anyway, but when you really listen to the patient’s story, sometimes that is not the right thing to do.”

Silence Kills was conducted immediately before AACN's national standards for healthy work environments were released. It identified seven concerns that often go undiscussed and contribute to avoidable medical errors. It linked the ability of health professionals to discuss emotionally and politically risky topics in a healthcare setting to key results like patient safety, quality of care, and nursing turnover, among others.

The Silent Treatment shows how nurses' failure to speak up when risks are known undermines the effectiveness of current safety tools. It then focuses on three specific concerns that often result in a decision to not speak up: dangerous shortcuts, incompetence, and disrespect. The Silent Treatment tracks the frequency and impact of these communication breakdowns, then uses a blend of quantitative and qualitative data to determine actions that individuals and organizations can take to resolve avoidable breakdowns.

Background

When communication breaks down, it breaks down in two very different ways. Business theorist, Chris Argyris, groups these breakdowns into two categories: honest mistakes and undiscussables. Each category has a different cause, produces a different range of outcomes, and requires different solutions. Honest mistakes include accidental or unintentional slips and errors—for example: poor handwriting, confusing labels,
Driving Forces for Partnership

• Bring students into the safety/quality culture of the clinical agency

• Promote students’ contributions to synergize actions of the staff in promoting safe patient care & accountabilities for quality standards

• Position students as assets vs. a potential liability
The Synergy Partnership

• University SON & tertiary medical center

1. Increase awareness & knowledge among students & agency staff of accountabilities for patient safety & quality outcomes

2. Promote application of safety & quality knowledge to nurse-managed patient care

3. Develop skills & enhance effectiveness of team communication & behaviors
Partnership Infrastructure

- Principles
- Relationships
- Accountabilities
- Operations
- Resources

USF School of Nursing
California Pacific Medical Center
Spring 2008
The Synergy Partnership

• Seven elements
  – Establish participant commitment
  – Clarify profession actions & accountabilities
  – Structure integration of student learning with clinical practice of agency nurses & physicians

• Provide evidence-based, best-practice content & process resources

• Measure student gains in safety & quality knowledge & increased role confidence
Initiating the Partnership

• Faculty sponsor
• Clinical instructors
• Resource manual
  – Content & process
  – Organizing tool
  – Partnership discussions
• Curricular Integration
Professional Accountabilities

• Academic
  – Dean, Quality & Safety Officer
  – Faculty Partnership Sponsor
  – Clinical instructors
  – Students

• Service
  – Senior Leadership
  – Unit Managers, Staff, Physicians
Clinical Agency Alignment

Senior leadership (visibility, engagement)

• Meet students at start of semester
  – Explain agency mechanisms for measurement & monitoring of safety & quality outcomes
  – Core measures (nursing-care sensitive)
  – Staff accountabilities (expectations)
Clinical Agency Alignment

Unit Manager
• Communication & support
• Partnership goals, principles, operations

Nursing Staff
• Student engagement & supervision
  – On-shift briefing, mid-shift huddle
  – Review of student assignment sheet
  – Know “patient safety spotlight”
Clinical Agency Alignment

Medical Staff

• Engage student in patient rounds
  – Clarify medical goals for shift & discharge
  – Solicit nursing input
  – Discuss “patient safety spotlight”
  – Model physician role
Prerequisite Knowledge Assess

- Administered during first clinical shift
- Assessment of content & process
Content

Prerequisite Knowledge Assess

1. What is SBAR?
2. For what purpose is SBAR used?
3. Describe all that you know about the National Patient Safety Goals.
4. List the National Patient Safety Goals.
5. What are nursing care-sensitive outcome indicators?


7. List 3 nurse interventions for pressure ulcer prevention.
Thinking back to your most recent clinical rotation, please indicate your perceptions as you remember them.

On a scale of 1-5  (1 = least & 5 = most)
Process
Prerequisite Knowledge Assess

8. How **prepared** do you feel to begin each clinical shift just BEFORE the shift starts?

9. How **available** are opportunities for communication among healthcare team members related to individual patients **DURING** your shift?

10. How **effective** is communication among healthcare team members related to individual patients **DURING** your shift?
11. How available are opportunities to review and discuss events of the clinical shift you JUST FINISHED?

12. How effective are opportunities to review and discuss the events of the clinical shift you JUST FINISHED?

13. In the clinical setting, how much impact do you as an individual have on patient care outcomes?
Tools & Resources

Content

• Evidence-based practice references
• Best practices & protocols
• Human factors
• Nursing-care sensitive patient outcomes
• National Patient Safety Goals
• Safety checklists primer
• Rapid Response Teams . . . etc. ....
Tools & Resources

Process

- Patient handover standards
- Safety checklists, agency protocols
- TeamSTEPPS tools
  - SBAR & CUS communication scripts
  - DESC Conflict management script
  - Two-challenge rule: assertive advocacy
Tools & Resources

Process

• Communication Process Cards
  – Pre-shift briefing
  – In-shift huddle
  – Post-shift debriefing
Safety/Quality Communication Process

Pre-Shift Briefing (student focus)

- CALL OUT: Risk & Harm Reduction Spotlight for this shift
- IDENTIFY available resources (staff nurse, charge nurse, instructor, protocols)
- CALL OUT: predicted needs for guidance and supervision
<table>
<thead>
<tr>
<th>In-Shift Huddle (patient &amp; process focus)</th>
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<tbody>
<tr>
<td>- CHECK POINT: Actions taken for Risk &amp; Harm Reduction <em>Spotlight</em></td>
</tr>
<tr>
<td>- CHECK POINT: Status of plan to manage patient’s current needs</td>
</tr>
<tr>
<td>- CALL-OUT: actions to manage patient outcomes by discharge</td>
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<tr>
<td>- CHECK POINT: Assessment effectiveness of team communication for plan of care</td>
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</table>
Post-Shift Debriefing (patient, student, team focus)

- REVIEW outcomes of actions taken for Risk & Harm Reduction Spotlight
- REFLECT: How is patient’s condition different at end of shift compared with start as a result of nursing actions? (nursing-sensitive outcomes)
- REFLECT: Name one new skill experienced and rationale for your actions
- REFLECT: What nursing interventions worked & what didn’t for patient outcomes?
- REPORT: Observations of teamwork effectiveness, barriers, missed opportunities
Tools & Resource Process

Risk and Harm Reduction SPOTLIGHT for this week:

- Pt Safety Behaviors
- 2 Patient Identifiers
- Critical Values (VS; labs)
- Patient Falls
- Restraints Management
- Standardized Abbreviations
- Hand-Off (per agency)
- SBAR/communication
- Team/roles/delegation
- Patient Satisfaction
- "Speak Up" (patient involvement in own care)
- Nursing Care-Sensitive Indicators
- National Patient Safety Goals
- Med Reconciliation
- Med Administration: LASA (Look Alike, Sound Alike)
- Pressure Ulcer Prevention
- Safety Checklist (high-risk task/procedure)
- Hand Hygiene
- Standard precautions; personal protective equipment; isolation

USF Lecture Material
(Junior 1: Correlate with daily patient selection & discussion)

- Chronic Disease / Organ Transplant / IV / CVC
- Peri-Op / Burns, Pulmonary (l & surgery)
- Blood Transfusions, Immunocompromise
- Chest Tubes / Tracheostomies / Airway suctioning
- Cardiology / CVS / Dysrhythmias / Pacemaker

- Renal failure / transplant / dialysis
- Shock / GI bleeding / Enteral Nutrition / TPN
- GI Dysfunction / GI Surgery / Ostomy Care
- Biliary / Pancreas DKA / HHNS
- Neuro (stroke) / orthopedics / endocrine
Process

• Patient Safety Spotlight badges
Acute care patients discuss the patient role in patient safety

Cheryl Rathert
Nicole Huddleston
Youngju Pak

Background: Patient safety has been a highly researched topic in health care since the year 2000. One strategy for improving patient safety has been to encourage patients to take an active role in their safety during their health care experiences. However, little research has shed light on how patients view their roles.

Purpose: This study attempted to address this deficit by inductively exploring the results of a qualitative study in which patients reported their ideas about what they believe their roles should be.

Methodology: Patients with an overnight stay in the previous 90 days at one of three hospitals were surveyed using a mailing methodology. Of 1,040 respondents, 491 provided an open-ended response regarding what they believe the patient role should be.

Findings: Qualitative analysis found several prominent themes. The largest proportion of responses (23%) suggested that patients should follow instructions given by care providers. Other prominent themes were that patients should ask questions and become informed about their conditions and treatments, and many implied that they should expect competent care. Our results suggest that patients believe they should be able to trust that they are being provided competent care, as opposed to assuming a leadership role in their safety.

Practice Implications: Our results suggest that engaging patients in safety efforts may be complex, requiring a variety of strategies. Managers must provide environments conducive to staff and patient interactions to support patients in this effort. Different types of patients may require different engagement strategies.
Awareness & Dialog Prompts

Synergy Partnership for Patient Safety & Quality

- Promotes safety & quality awareness & action for all aspects of nurse-managed patient care
- USF nurses in training & agency nurses in practice partner to focus on safe, quality patient outcomes
- Today’s safety / quality spotlight is:
Synergy Partnership Study

• Descriptive pilot study design

• Convenience sample:
  – 24 students enrolled in a 3rd semester, prelicensure clinical nursing course

• Measured pre & post clinical rotation:
  – students’ safety & quality knowledge
  – perceptions of team behaviors & communication effectiveness
  – confidence of impact on patient care outcomes
Study Findings

• Survey forms for 23 (response rate 95.8%)
• Aggregate means, effect sizes
### Student Performance on Pretest and Posttest Assessments (n=23)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Mean &amp; SD Pretest</th>
<th>Mean &amp; SD Posttest</th>
<th>Cohen’s d</th>
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<tbody>
<tr>
<td><strong>Part One: Knowledge</strong> (maximum score per item*)</td>
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</tr>
<tr>
<td>1. What is SBAR? (1*)</td>
<td>0.96 (0.21)</td>
<td>1.00 (0.00)</td>
<td>.42</td>
</tr>
<tr>
<td>2. For what purpose is SBAR used? (1*)</td>
<td>0.78 (0.42)</td>
<td>0.81 (0.40)</td>
<td>.07</td>
</tr>
<tr>
<td>3. Describe all you know about the National Patient Safety Goals (2*)</td>
<td>0.70 (0.70)</td>
<td>1.33 (0.66)</td>
<td>.94</td>
</tr>
<tr>
<td>4. List the National Patient Safety Goals (3*)</td>
<td>0.39 (0.66)</td>
<td>2.24 (1.09)</td>
<td>2.11</td>
</tr>
<tr>
<td>5. What are nurse-sensitive quality indicators? (1*)</td>
<td>0.17 (0.39)</td>
<td>0.48 (0.51)</td>
<td>.67</td>
</tr>
<tr>
<td>6. List the nurse-sensitive quality indicators (3*)</td>
<td>0.26 (0.62)</td>
<td>1.10 (1.14)</td>
<td>.95</td>
</tr>
<tr>
<td>7. List 3 interventions for pressure ulcer prevention (3*)</td>
<td>2.13 (1.01)</td>
<td>2.14 (0.91)</td>
<td>.01</td>
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### Part Two: Perceptions (Likert-type Scale: 1 least; 5 most)

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<thead>
<tr>
<th>Question</th>
<th>Mean (SD)</th>
<th>Median (IQR)</th>
<th>Range</th>
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<tbody>
<tr>
<td>8. How prepared do you feel before shift starts?</td>
<td>3.52 (0.73)</td>
<td>4.05 (0.51)</td>
<td>.85</td>
</tr>
<tr>
<td>9. How available are opportunities for communication among team members</td>
<td>3.65 (0.71)</td>
<td>4.08 (0.57)</td>
<td>.66</td>
</tr>
<tr>
<td>10. How effective is communication among team members during your shift?</td>
<td>3.82 (0.85)</td>
<td>4.00 (0.56)</td>
<td>.26</td>
</tr>
<tr>
<td>11. How available are opportunities to review and discuss events of shift</td>
<td>4.04 (0.82)</td>
<td>4.15 (0.59)</td>
<td>.15</td>
</tr>
<tr>
<td>12. How effective are opportunities to review and discuss events of shift</td>
<td>4.00 (0.74)</td>
<td>4.25 (0.64)</td>
<td>.36</td>
</tr>
<tr>
<td>13. How much impact do you as an individual have on patient care outcomes?</td>
<td>3.64 (1.05)</td>
<td>4.28 (0.79)</td>
<td>.70</td>
</tr>
</tbody>
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Academic-Service Partnerships

• Ensuring students develop the KSAs for patient safety & quality is a formidable challenge
Academic-Service Partnerships

Creating formal partnerships promotes synergy

• enhances clinical practice competencies
• encourages advocacy for patient safety
• builds students’ role confidence
The University of San Francisco