

Patient safety discussion toolkit for system expansion



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Introduction to the patient safety discussion toolkit for system expansion

The *Patient safety discussion toolkit for system expansion* has been developed for use by physicians during the pre-affiliation phase of a merger, acquisition, or affiliation of two organizations that provide clinical care.

Clinical affiliations lead to improved patient care when clinicians and staff at both organizations learn from one another and develop strong professional relationships. While network development administrators might turn their attention to other projects after affiliation, physicians will continue to work across diverse hospital settings. Thus, it is imperative that they develop relationships around joint problem solving.

This discussion toolkit can help clinical leaders identify differences in clinical practice, resources, and culture that are most likely to affect patient safety. The process of uncovering and discussing those differences can also help foster a climate of understanding, trust, and partnership.

Key goals:

- Both parties feel that they can trust and be trusted
- Articulate/prioritize areas that require change to be part of a common system
- Find opportunities to create something better together

Contents

The toolkit contains:

- *High-priority questions* (a subset of topics from the *All-specialty discussion guide*)
- *All-specialty discussion guide*
- *Supplemental obstetrics considerations*
- *Supplemental emergency medicine considerations*
- *Supplemental surgery considerations*

Each component contains a series of prompts for generating discussion around key topics. The topics are representative, not comprehensive. We recommend that you use them as a foundation for deeper exploration and discussion over time.

Begin with the *All-specialty discussion guide* as your main reference, then consider using the supplemental specialty-specific considerations as appropriate.

Within each guide, prompts are organized by category:

- Emergency situations
- Infrastructure and resources
- Roles and responsibilities
- Patient safety and quality improvement
- Culture [*All-specialty discussion guide* only]
- Quantitative patient safety parameters

How to use the discussion toolkit

Overview

Clinical leaders from each organization should work together to review and explore the discussion prompts. In many cases, it is helpful to engage an independent facilitator to help guide the process. The amount of time and number of meetings required will vary greatly depending on size and complexity of the organizations and the type of affiliation, as well as the individual culture of the organizations. Expect the process to be faster when both parties are transparent regarding motives and resources and are willing to compromise.

Clinical leaders should feel empowered to modify, add, subtract, and adapt the discussion guides to fit the needs of each unique affiliation.

Tips

- Involve clinical leaders from each organization in all communications.
- To prioritize relationship building from the beginning, have the first meeting be over a meal at a non-hospital location.
- Consider using an experienced and objective facilitator with relevant clinical expertise to lead the clinical discussions between affiliating entities.
- Plan longer or additional meetings to engage other staff with complementary perspectives (e.g., Nursing, Quality Improvement).
- Share best practices — and when creating new standards, ensure that best practices from each affiliating entity become part of the new practice standards of the joint entity.
- Ask repeatedly, “What can we do better together than we could do alone?”

How do you know when you are done?

Transforming two (or more) clinical organizations into a single patient-safety focused system is an ongoing process. The reality is that clinical discussions are embedded in other negotiations and the pacing is likely to be influenced by other factors. Identifying differences and reaching consensus around the prioritization of resolving those differences is an excellent first step.

You will know that you have made good progress when clinical leaders:

- feel that they have established a trusting relationship so they can solve future (currently unanticipated) problems.
- have agreed upon and prioritized key areas of difference that may affect patient safety.
- have agreed upon a plan to address those differences.
- have collaborated with non-clinical partners to develop and agree upon a plan for joint clinical governance and measures of progress toward meeting and sustaining program goals.

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References

All-Specialty

SOURCES

- CRICO System Expansion Retreat: October 2015
- CRICO Working Group meetings: November 2015, February 2016
- CRICO Leadership input
- CRICO chiefs of Emergency Medicine (EM), Obstetrics (Ob), and Surgery and individual Attending (12 total in EM, OB, Surgery, and Anesthesia)

CITATIONS

- WMS Survey: <http://worldmanagementsurvey.org/academic-research/healthcare/>
- How Culture Affects Mergers and Acquisitions. Miller, Robert. Industrial Management 2000

Emergency Medicine

SOURCES

- CRICO EM chiefs' meetings
- Literature review
- Interview with chair of the CRICO EM chiefs group and two EM frontline physicians

CITATIONS

- Framework for quality and safety in the emergency department. International Federation for Emergency Medicine, 2012
- Graff et al. Measuring and improving quality in emergency medicine. Academic Emergency Medicine. 2002;9(11)
- Sayed et al. Measuring quality in emergency medical services: a review of clinical performance indicators. Emergency Medicine International. 2012, Article ID 161630
- AHRQ Hospital Survey on Patient Safety <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/hospscanform.pdf>
- CMS Hospital Compare (HCAHPS and Clinical Results): <https://www.medicare.gov/hospitalcompare/search.html>
- Pediatric Life Support Guidelines: http://cpr.heart.org/AHA/ECC/CPRAndECC/Training/HealthcareProfessional/Pediatric/UCM_476258_PALS.jsp

Obstetrics

SOURCES

- CRICO Ob chiefs' meetings
- Literature review
- Interview with two chiefs and two frontline physicians with affiliation experience
- CRICO Obstetrics Clinical Guidelines <https://www.rm.f.harvard.edu/Clinician-Resources/Guidelines-Algorithms/2014/OB-HTML-Guideline-Home-Page>

CITATIONS

- AHRQ Hospital Survey on Patient Safety <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/hospscanform.pdf>
- Mann et al. Assessing quality in obstetrical care: development of standardized measures. Journal on Quality and Patient Safety. 2006;32(9).
- CMS Hospital Compare (HCAHPS and Clinical Results): <https://www.medicare.gov/hospitalcompare/search.html>

Surgery

SOURCES

- CRICO Surgery chiefs' meetings
- Interviews with practicing surgeons and anesthesiologists and perioperative services nurse manager (six total)

CITATIONS

- Birkmeyer et al. Measuring the quality of surgical care: structure, process, or outcomes? Journal of American College of Surgeons. 2004;198(4)
- AHRQ Hospital Survey on Patient Safety <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/hospscanform.pdf>
- CMS Hospital Compare (HCAHPS and Clinical Results): <https://www.medicare.gov/hospitalcompare/search.html>

High-priority questions

Instructions for clinical leaders: The following subset of prompts from the *All-specialty discussion guide* can be used to explore areas of difference that can significantly impact patient safety. If you can only work through a short list of topics, start with these.

<p>Emergency situations</p>	<p>Describe how you call and run a code your institution.</p>
<p>Roles and responsibilities</p>	<p>What services are not available on nights and weekends?</p> <p>Who is responsible for each step of a transfer to the ICU, from decision to transfer to completion of relocation?</p>
<p>Infrastructure and resources</p>	<p>What is your protocol for identifying and transferring patients into or out of a unit when their clinical complexity no longer matches the unit's ability to care for them? (Consider both intra- and inter-hospital transfers.)</p> <p>Describe your ICU(s).</p> <ul style="list-style-type: none"> • Open unit or closed? • Intensivist-led? • Who is in-house during nights and weekends? • What coverage does an intensivist provide on nights and weekends? • What can be accomplished in the ICU overnight and during weekends? (e.g., line placement, dialysis initiation)
<p>Patient safety and QI</p>	<p>Describe how each department collects, aggregates, and trends complication rates.</p> <ul style="list-style-type: none"> • Does each department determine what to track? • How do you ensure that all departments collect and report information in a similar way? <p>Describe your policy and procedure for handoffs when the responsible clinician changes.</p> <p>Describe how your institution does mock drills.</p> <ul style="list-style-type: none"> • format? • frequency? • content? • participants?
<p>Culture</p>	<p>How are quality metrics (such as survival rates, infection rates, and patient satisfaction) made visible to institutional leaders and to frontline staff?</p> <p>What factors influence the appointment of department chairs?</p>

All-specialty discussion guide

Instructions for clinical leaders: Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

Emergency situations

Describe how you call and run a code at your institution.
How are physicians oriented to institution-specific emergency resources?
How and when are crisis checklists used?
How is your hospital's massive transfusion protocol activated for obstetric and non-obstetric hemorrhage?
Describe your institution's disaster plan and related staff training.

Roles and responsibilities

What services are not available on nights and weekends?
How do you transfer a patient to the ICU?
How many shifts must physicians (including those "visiting" from other institutions) complete on a regular basis to maintain proficiency with current and new institutional practices?

Roles and responsibilities

Describe the orientation you provide for physicians new to your organization.

Describe the ways in which you resolve disagreements between professional staff about medical management.

How do you define the scope of practice for Advanced Practice Clinicians (APCs) and what are your rules for physician supervision of APCs?

EXAMPLES

- prescribing (controlled substances)
- presence at certain procedures (extubation, minor surgery)

What is your system for ensuring that Residents and Attendings have a common understanding of Resident responsibilities and supervision?

Infrastructure and resources

What is your protocol for identifying and transferring patients into or out of a unit when their clinical complexity no longer matches the unit's ability to care for them?

(Describe what is included for both intra- and inter-hospital transfers.)

Describe your ICU(s).

- Open unit or closed?
- Intensivist-led?
- Who is in in-house during nights and weekends?
- What type of coverage does the intensivist provide on nights and weekends?
- What can be accomplished in the ICU overnight and during weekends (e.g., line placement, dialysis initiation)?

Infrastructure and resources

<p>Describe your computerized physician order entry (CPOE).</p>
<p>Describe your electronic medical record (EMR) and identify components within the EMR that are not interoperable.</p>
<p>Describe how one accesses past medical history of patients.</p>
<p>What is the system for reconciling medications at your institution?</p>
<p>Do you have a policy for nurse staffing based on staff-to-patient ratios, and what are your target ratios?</p>
<p>Describe your system for assessing and documenting nursing staff competence.</p>
<p>What decision support tools can physicians access? (e.g., Up to Date, Isabel)</p>
<p>During what hours is a clinical pharmacist available?</p>
<p>What are your expectations for the availability and response time of consultants?</p>
<p>What are your expectations for how consultants communicate with other physicians and patients?</p>
<p>Describe your use of telemedicine services.</p>

Infrastructure and resources

What resources are available for the care of infants and children?

What is the discharge process for patients?

- How do you confirm that patients have understood discharge instructions?
- How does the responsible outpatient physician receive handoff information following discharge?
- In what ways do you touch base with patients after they leave the hospital? (e.g., to check on them or to ensure appropriate outpatient follow-up?)

What is your process for integrating new technologies (e.g., robotics, laser) and how do you train physicians and nurses on those new technologies?

Patient safety and quality improvement

Describe your process for incorporating new guidelines into your practice standards.

Describe how each department collects, aggregates, and trends complication rates.

- Does each department determine what to track?
- How do you ensure that all departments collect and report information in a similar way?

Describe your policy and procedure for handoffs when the responsible clinician changes.

Patient safety and quality improvement

Describe how your institution does mock drills.

CONSIDER

- format (e.g., team briefings vs. huddles)
- frequency
- content
- participants

How can we work together to improve patient safety?
To improve quality of care?

What are your surveillance systems for actively measuring misdiagnoses, delays in care, and inappropriate therapies?

What are the follow-up systems for abnormal labs and radiology?

Describe the system used by your hospital to identify when consults and referrals have not been completed in a timely way, and describe how the requester is notified.

Describe your system for closed loop communication of patient laboratory and radiology results (including after discharge).

Describe your policy and procedure for disclosing adverse events and outcomes to patients.

How do you assess patient experience and family engagement in care?

- What is your system for addressing negative patient and/or family experiences?

Patient safety and quality improvement

Describe your electronic capture system for reporting safety events.

Describe how your institution makes quality measures easily comparable across departments.

Describe your protocols for improving the perioperative safety of high-risk patient populations.

EXAMPLES

- obese patients
- elderly patients
- frail patients

Describe your hospital's Patient Safety and Quality Improvement (PSQI) Committee.

- How often do they meet?
- What are your hospital's main PSQI goals?
- What are the two most recent changes that the hospital enacted as a result of the PSQI Committee's work?

Culture

How are quality metrics (such as survival rates, infection rates, and patient satisfaction) made visible to institutional leaders and to frontline staff?

What factors influence the appointment of department chairs?

What are the biggest drivers of patient care decisions at your institution?

What barriers (if any) do you experience as you try to accomplish your work?

Quantitative patient safety parameters

How often does your hospital board discuss patient safety and quality improvement issues?

Is your CEO aware of infection rates?

How many root-cause analyses occurred at your hospital last year?

When was the last time your hospital reported a serious event to the Department of Public Health and what was it?

What is the percentage, overall and for each relevant department, of “Yes” responses to the HCAHPS survey question:

“Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?”

What is the percentage, overall and for each relevant department, of “Agree” and “Strongly Agree” responses to the HCAHPS survey question:

“When I left the hospital, I clearly understood the purpose for taking each of my medications.”

Supplemental obstetrics considerations

Description: This guide presents a list of obstetrics-specific considerations that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

Instructions: Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

Emergency situations

Describe your system for maternal resuscitation, including a designated response team from anesthesia, pediatrics, and a surgical airway manager, and describe which personnel are available by time of day and day of week.

Describe your use of a checklist for management of obstetric hemorrhage and hypertensive crisis.

Roles and responsibilities

What are the unique and overlapping roles of physicians and CNMs?

Infrastructure and resources

Describe your protocol for the use of oxytocin.

EXAMPLES

- indications
- initial and incremental doses and intervals
- dose reductions/stopping

Describe your policy and procedure for scheduling early elective delivery.

What is included in your guidelines for circumcision?

EXAMPLES

- contraindications
- elements of consent
- surgical pause
- pain relief
- qualifications of performing clinicians

What is included in your protocol for identification and transfer of patients into or out of a unit when their clinical complexity no longer matches the unit's ability to care for them?

Patient safety and quality improvement

What is included in your guideline for care of pregnant women after prior cesarean?

EXAMPLES

- elements of counseling
- antepartum diagnosis of abnormal placentation
- intra-operative contingency planning
- backup for VBAC

Describe your perinatal QI committee.

- Does it include representatives from pediatrics, anesthesia, nursing, and midwifery?
- How often do they meet?
- How do they review trended quality data and individual cases?
- How do they oversee improvement work?

Does your organization use a pre-procedure safety checklist before all obstetric procedures?

- What does your checklist include?

Describe your team trainings for OB emergencies.

CONSIDER

- Who is included?
- How frequently do they occur?
- What topics have been covered in the last 2 years?

Quantitative patient safety parameters

What are the ratios of delivering patients per OR and per L&D room last year?

What was the nulliparous term singleton vertex (NTSV) cesarean rate last year?

How many obstetric morbidity and mortality conferences occurred last year?

How often is each provider's competency in EFM interpretation assessed?

Supplemental emergency medicine considerations

Description: This guide presents a list of emergency medicine – specific considerations that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

Instructions: Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

Emergency situations

How does your existing equipment for managing pediatric emergencies compare with the 2010 AAP/ACEP/ANA guidelines?

Roles and responsibilities

Which physician decides whether a patient in the Emergency Department (ED) will be admitted and to what service?

What are the criteria for staffing the ED (e.g., Board Certification status of physicians) and what are the physicians' designated responsibilities?

EXAMPLES

- ability to admit
- involvement in patient work-up

Describe the orientation for all new providers in the ED.

Describe your OPPE/FPPE processes.

Roles and responsibilities

Describe how you manage critical conditions.

EXAMPLES

- STEMI
- aortic dissection
- spinal cord injury
- sepsis
- airway emergency
- pediatric emergency

Infrastructure and resources

What are your Emergency Department (ED)'s internal resources to manage codes involving:

- intubation
- septic shock
- complex intubation
- critically ill patient
- surgical airway
- cardiopulmonary resuscitation

Describe how the capabilities of inpatient units and on-call staff are reflected in your criteria for:

- hospital admission
- transfer out of the ED for specific conditions

Describe your mechanism for scheduling outpatient follow-up prior to a patient's departure from ED.

How many shifts per month are staffed with nurses trained in Pediatric Advanced Life Support or Advanced Pediatric Life Support?

Patient safety and quality improvement

Describe your Emergency Medicine QI committee.

- Which services participate?
- Which professionals (e.g., physicians, nurses, etc.) participate?
- How often do they meet?
- How do they review trended quality data?
- How do they oversee improvement work?

Describe your physician peer-review process.

EXAMPLES

- participants
- regular meetings
- standardized evaluation criteria
- tracking of results
- feedback of all evaluations to providers

Quantitative patient safety parameters

What percentage of ED physicians are board certified/eligible or highly experienced in emergency medicine?

What are the patient-to-staff ratios (actuals, not targets) for nurses on each shift?

How many patients per hour do you expect physicians and APCs to see on each shift?

What was your staff turnover rate (all non-physicians) last year?

Quantitative patient safety parameters

What is the average response time to a page for a consult to the ED?
What proportion of patients return to the ED within 72 hours of discharge?
How many times were peer-protected, multidisciplinary case review conferences held last year?
How many “Never Events” did you have in the last 12 months?
Percentage of arrivals who left without being seen last year.
Percentage “Good” or “Excellent” on patient survey question: <i>“Likelihood of your recommending our Emergency Department to others”</i>
What proportion of patients are children? (Both under 16 years and under 2 years)

Supplemental surgery considerations

Description: This guide presents a list of surgery- specific considerations that affiliating organizations should jointly consider, with a goal of increasing the value of care for their joint patient population.

Instructions: Working together, consider the following discussion prompts as you seek to make explicit the similarities and differences between your organizations and collaborate on how you can protect and improve patient safety.

Emergency situations

How does one get help for airway emergencies during nights and weekends?

Describe the on-call availability of vascular surgeons and thoracic surgeons (include variation on nights, weekends, and holidays).

Describe your protocol for identifying and transferring patients whose clinical complexity exceeds the unit's ability to care for them on the floor.

Are there cases and conditions for which this hospital's anesthesia department is not comfortable or equipped to provide care?

Roles and responsibilities

What do you do to foster a team approach in the OR?

Infrastructure and resources

What roles do physicians play in your pre-admission testing center?

CONSIDER

- Who sets standards?
- How are services/consults accessed?
- What is measured?

What criteria do you use for establishing operating privileges (which operations a surgeon may schedule)?

What are the guidelines for surgical and medical staff coverage on nights and weekends?

What is the availability of critical consulting services (cardiology, renal, and infectious diseases) at night and on weekends?

What is the policy for doing cases in the operating room overnight and/or on weekends?

Explain how the pre-operative process assures that there is sufficient information and time to make certain that a patient undergoing an elective surgery is optimized for that surgery.

Patient safety and quality improvement

Describe your system for tracking operative complication rates in each department.

What is your policy on concurrent surgery?

What is your policy on procedural volume standards?

Quantitative patient safety parameters

How many morbidity and mortality conferences occurred last year?