Acting on Real-Time Patient Reports to Improve Safety

Ioana Popescu:

[0:00:00] Well, hello, everyone. It is my pleasure to welcome you on today's webinar. We are talking about Acting on Real-Time Patient Reports to Improve Safety. My name is Ioana Popescu, I'm a Patient Safety Improvement Lead with the Canadian Patient Safety Institute. And my role here is to lead programs related to patient engagement, including supporting patients for Patient Safety Canada, the patient-led program of the Canadian Patient Safety Institute and the Canadian arm of the World Health Organization, Patients for Patient Safety Program.

Today's webinar had a slightly different storyline than the previous ones hosted by Patients for Patient Safety Canada. It actually started with a recognition program that we had in place, and this year, during that recognition program, we identified 15 leading practices of patient engagements to improve patient safety.

Out of the 15 leading practices we recognized, three of them were approaching real-time patients reporting of their care experience, including safety. So, patients for Patient Safety Canada members were very excited to learn about that and decided to host this webinar for you.

The partners in this recognition program are Healthcare Can and Health Standards Organization. I heard that Jessica, the Director for Quality Performance and Evaluation at Healthcare Can is on the line, and I know her audio's working. So, let's see if Jessica has a few welcoming words for you.

Jessica:
[0:01:39] Thanks, Ioana. And welcome to everybody to today's presentation, and thanks to the three organizations that will be sharing their leading practices and lessons learned today.

As Ioana said, I work with Healthcare Can, we're a national healthcare association and our members are healthcare organizations across the country, including the presenters today, their organizations as well. And my role at Healthcare Can is to help develop and deliver learning programs, as well as other spread and knowledge translation initiatives related to quality, patient safety, and of course, patient engagement across learners all over our country. And we're very proud to be a partner in this recognition program that Ioana described with CPSI and HSO. It's been a tremendous opportunity to learn about some amazing practices that are happening in Canada and to help share them with others in the country.

And we're also proud, of course, to work with CPSI in Patients for Patient Safety Canada and other learning programs like the Canadian Patient Safety Officer Course. So, thanks, Ioana, for involving us today, and I'm really looking forward to hearing the presentation.

Ioana Popescu:
[0:02:48] Of course, it is our pleasure. Before we begin the program, we have a few key points to walk you through our virtual meeting room. So, Janet, if you can go to the next slide. First of all, know that your safety is our first priority. You need to know where the fire exits are. No, I'm

kidding. Obviously, you know where the fire exits are. The slides and the recording from this session will be made available on our website later on. So, just know that this session is recorded. However, our conversation in the chat box will not be included in that recording, so feel free to share there.

[0:03:27] As in previous webinars, we want the participants list to be visible. We want you to know your colleagues who are on the line, and maybe make a new friend. I noticed we have many old friends: Andrew, Valerie, <indiscernible 00:03:40>, Lori, and many others who have been with us on other webinars. Welcome to our new friends and our old friends.

So, because of the numbers, we expect around 300 participants on the call today, we can only create this dialogue via chat. So, please locate the chat box on the right lower hand corner of your screen and begin to communicate with your colleagues. Maybe you can start by telling us what city you're in and what's your role.

Today we're gonna try to tweet. So, if you are inclined to tweeting and you can do that, please use the hashtags we have here on the screen. We have them later on in the slides too, so don't worry about that. And if you hang on until the end of our presentation, we have a slide with resources as well as a very short evaluation. We want to know how we did and what topics do you want us to consider for future webinars?

[0:04:36] And with this, it is my pleasure to now introduce our moderator for today's session. Theresa Malloy Miller is joining us today from Delaware, Ontario. She's one of the founding members of Patients for Patient Safety Canada, and was a Patient Partner in our group since 2006. I'm just gonna pause a moment and ask you to join me in thanking Theresa for the many years of contributions to patient safety. She has definitely inspired thousands over years, including me, with her passion.

It all started with a tragic and preventable loss of her son, Daniel, that changed the course of her life and brought her to Patient Engagement. That unimaginable pain, combined with her determination, turned to be a force that resulted in disclosure and safety improvement in the organization where Daniel's incident happened. And then after she joined our group, she influenced many Canadian initiatives, including Engaging Patients in Patient Safety, a Canadian Guide. Theresa is currently the lead for the Patients for Patient Safety Canada Knowledge Transfer Working Group, and you've met her if you joined our previous webinars, because she is the moderator of many Canadian and global webinars designed by patients for patients and providers.

So, please help me to welcome Theresa in our webinar. Did you find the virtual applause button? Theresa, over to you.

Theresa Malloy Miller:
[0:06:05] Hello and welcome, everyone. I just got disconnected. So, in the last few seconds I've gotten back on. Ioana, did you change the order of who we're presenting first?

Ioana Popescu:

[0:06:16] No. Let's begin with Alberta Health Services. But before, we have the objectives and the agenda on the screen, Theresa, if you just want to take the participants through that first.

Theresa Malloy Miller:

Okay. So, we're delighted to have everyone here today. So, our first, as Ioana said, our first presenters are from Alberta Health Services. Kathy Kovacs Burns is an academic scholar, a professor, a researcher with the School of Public Health at the University of Alberta. She's also a senior consultant with Alberta Health Services. Her big focus is on patients and families, as well as healthcare providers, and certainly with an emphasis on quality and healthcare improvement.

She's also a member of Patients for Patient Safety Canada, which we're very delighted. She's a strong patient voice that is heard locally, nationally, and internationally in her volunteer work and in her research. She engages with partners, with patients, with families, and always looking to improve healthcare services for everyone.

[0:07:26] Also joining Kathy is Marian George. After a career as a healthcare professional and educator and an academic, she's now volunteering as a Patient Advisor. She developed her patient experience through the birth of new family members, through her own personal and family members’ healthcare experiences, through communication with health specialists and being a part of the final journey of some of her family members. She has always emphasized a shared journey with health professionals. Currently she's a Patient and Family Advisor with Alberta Health Services. She co-designed their real-time feedback system that they're gonna describe for us in a minute. And she just does lots and lots of things, so we're delighted to have Kathy and Marian start us off today. Go ahead.

Kathy Kovacs Burns:
[0:08:21] Hello? Can you hear me?

Theresa Malloy Miller:

[0:08:22] Yes, I can

Kathy Kovacs Burns:

[0:08:23] It’s Kathy. Oh, great. Thank you. I'm on phone, so I'm gonna have to have help with the slides. But thank you very much for inviting us. We're delighted to be able to talk a little bit about some of the work that we're doing at Alberta Health Services. So, Marian and I are going to co-team, co-speak and present. We are co-team, absolutely. And so, if you can just turn to the, the next slide. I'm not sure who's advancing the slides, I don't have access now, I don't think.

Oh, can you see that?

Theresa Malloy Miller:

[0:09:01] Yes. Yes. We’re seeing it.

Kathy Kovacs Burns:

[0:09:02] Okay. So, maybe I do have access. Okay. Yeah, so that's our presentation. It's looking at patient and family volunteers or advisors gathering real-time patient experiences, and it is based on some pilot work as well, which we'll talk a little bit about. Now, let me just see how I advance this. Oh, dear.

Theresa Malloy Miller:

[0:09:27] Janet, can you advance slides?

Kathy Kovacs Burns:

[0:09:28] Here we go.

Theresa Malloy Miller:

[0:09:28] You did it?

Kathy Kovacs Burns:
[0:09:28] I think. There we go. Yes. So, there's a number of people that we really want to acknowledge here. It takes a huge team and a community to actually change culture and to move forward with a new innovative approach to being able to measure patient family experiences. So, we definitely want to acknowledge all the patients and families and caregivers that were part of our initiative, the advisors, and of course Marian is a co-lead with me in terms of this work. But certainly, the unit managers, the staff and clinicians, senior leadership has been very supportive. And of course, all my colleagues who are part of Clinical Quality Metrics Engagement, Patient Experience and, and Quality Improvement. So, without them, we probably would not be able to proceed with a lot of our work.
[0:10:22] So, we're just gonna take you through very quickly some of the challenges that we've experienced around patient- and family-centred care. I don't think it's unique to Alberta Health Services. Every health system has some of those challenges. We're gonna talk a little bit about the approach to address the identified issues and challenges. Some of our experiences and even our lessons learned to date because we're still in that process of learning and moving forward. And a little bit more about sustainability and feasibility for moving forward on this on a larger scale.
[0:10:54] So, I just want to start off talking a little bit about the challenge for staff and clinicians. And again, not unique to AHS, but we do know there's lots of good data, data sources, and AHS is rich in data. The problem is that the staff really don't know that some of the data exists. And for those staff who do know it exists, they don't have the time to dig through everything to find what is useful for their particular unit or their program or situation. Most staff really don't use the big data, actually, even for their quality improvement because they're not sure how to sort of look at the data and then to bring it forward to talk about. So, where can we improve?

So, what they're saying, is we need some real-time patient experience data. None of us have that capacity to gather it. What advice can leadership give us in terms of helping us move forward?

And so, I'm gonna turn this over to Marian now, because one of the key pieces is the challenges that affect patients and, of course, patient and family-centered care.

Marian George:
[0:12:02] Thanks, Kathy. Hello, everyone. I think I'm off now. Can you hear me now?

Theresa Malloy Miller:
[0:12:08] Yes, I can hear you.

Marian George:

[0:12:10] Okay. Thank you. Anyways. Hello, everyone, and thanks, Kathy. So, with these challenges, what we've recognized is nothing really – sometimes things don't change very quickly. There are delays, there's the time lapse where people can't get to dealing with the issue, there’s capacity issues as to, you know, who can actually do it. And, you know, really once the change was implemented, then how do we know if it’s made any difference? So, these are the challenges that we've recognized.
[0:12:48] What we've also recognized is, the good news for us, in Alberta anyways, and I think across Canada, is health organizations are certainly focusing on embedding the patient- and family-centered care into everything they do. However, we still are running into the issues with capacity. How do you get this done? How do we experience the real-time data? It's not easy, it's very busy, but in the end of all of that process, the patient is still experiencing what they've always experienced a fair bit of the time.

So, our approach? Well, the ideal would be to have dedicated staff that is looking after this process, gathering data on the units or in community. However, that's not realistic all the time. And the other piece that I'd like to add to that as a patient advisor, is there can be a power difference there. When you have a staff member collecting the data, it can make a difference. And Kathy has a wonderful story of how they just by chance came across an experience where they had to – or they decided to try and utilize volunteers and had a volunteer collect data, and found that the volunteer, due to the relationship with the patients, was able to collect rich data, very rich data, compared to the staff member. So, very interesting.

[0:14:19] So, what we have come up with is our new strategy of training, partnering with the volunteers or family advisors that are within the province and try a pilot doing this. And currently, we have units in acute care, we also have some community care and participation, one area in each of the five zones within the province. It's extremely exciting.

So, what we're doing is we work with the patient advisors, they are right there at the beginning, at the orientation with the staff. We go through the patient data; we look for improvements. There's a co-design, because everyone is sitting at the table, and then the advisors will be going out and collecting real-time data.

How this is done? Kathy's going to share that now, and I pass it back to Kathy. Kathy, certainly when she comes back in, please. Let me know.

Theresa Malloy Miller:
[0:15:15] Yeah. Right.

Marian George:

[0:15:17] All right, let's move on to the next slide here then. So, looking at the patient concerns. So what these slides – the next few slides are showing, an example unit. So, what Kathy does in particular, is we take the information that she has from the various sources within Alberta, and offers feedback on what each of those staff information is showing. And as we look at that, we start to identify key areas of concern with the staff. However, as she is doing this, she also goes to the fishbone cause and effect to start to kind of go back on the previous information that's been gathered to identify what are some of the causes and effects of this, and where can the staff actually start to zero in?

Because remember, this is a pilot. We have to simplify things. And as Kathy calls it, we are looking at trying to approach the low-lying fruit and try and work with what we can work with in a short time because of the pilot. And we're looking at how we can aim at something, we can set a change and we can measure. So they go in, they decide on what they want to do as a quality improvement, how they could possibly do it. Our advisors are then able to go in and ask questions. We create the questions, a survey with the advisors. They go onto the units or in community with iPads with a very simple survey to collect real-time data.

Then they are able to – we take that data away. The staff are able to review what the information has been gathered, implement, they put an implementation of some sort of change, whatever they've chosen in. So, you can see it's that plan, do, study, act, that process. And then what we are able to do is – oh, is Kathy back on?

Kathy Kovacs Burns:

[0:17:19] I am back on. Sorry.

Marian George:

[0:17:21] There, Kathy, I hand it back to you. I got past – I'm doing the developing implement plans. I'm not sure if you were able to listen. So, I will leave it with you then, Kathy.

Kathy Kovacs Burns:
[0:17:32] Yeah, I'm sorry.

Theresa Malloy Miller:

[0:17:33]You've probably got one or two minutes, Kathy.

Kathy Kovacs Burns:

[0:17:41] Yep. So, we were doing, you're doing your great job. We'll wrap up in one or two minutes.
Sorry about the technology part on my end here.

Yes, so, the quality improvement is the, plan, do, study, act approach that we've used. And so, people do know that there is their aim. They have selected a change and now they want to measure and do some small tests of change to see if, in fact, their improvement has made a difference.

We have three buckets of measures we're looking at always: the outcome measures, process and balance. So, for outcome, it could be improved perceptions or experiences of patients. Even positive staff and healthcare provider perceptions, experiences, the process could just really be time-involved, you know, those kinds of activities, what it takes to get started and moving.
And then the balanced measures, which really looks at things that affect the organization generally. It could be workload, even. If, in fact, it increases the staff workload, then the chances of them being inclined to utilize advisors on an ongoing basis might not be quite so positive. So, all these measures are extremely important.

So, our lessons or experiences are showing us that the patient experience measurement is of interest, not just to patient advisors, but to staff, clinicians and organizational leaders. And it is important to gather real-time patient experience data aside from the big data that does exist for most organizations like HCAPs or, you know, those, those kinds of survey tools that have been validated for many years.

[0:19:17] Our advisors and volunteers are very keen to play a role. They do go through some training, and I think that that's natural. There's a co-design of initiatives that happens, and that's not always comfortable in the beginning, but people become accustomed to it. And once they get started, they find that there's definite advantages. So, as I mentioned, orientation, training and supports are really essential. And then understanding the experiences of the advisors and volunteers as well as the staff is equally as important as understanding those of the patient. And it's noteworthy to make sure that we look at the pre- and the post-results as we go through.

So, next steps - thinking of sustainability, is connecting all of those dots, finding out where the experiences really have been valuable, where there are still challenges, and looking at how we develop a framework for moving forward with utilizing more advisors and volunteers at the unit level to help staff and work with staff, partner with them in terms of some of the quality improvement.

And I just put a framework up there that we're utilizing now. But in the future, we hope to actually implement our own framework. We are using the quadruple aim, which most systems are using to measure performance, and that includes the patient experience, the healthcare provider experience, and certainly looking at cost factors or the organizational balance measures, and then, of course, how that impacts the population as a whole.

So, I think that that's really our last slide. Yes. Thank you.

Ioana Popescu:
[0:20:55] I want to thank both of you for the presentation. I'll remind the participants that your leading practice has been linked on the website for advertising the webinars so they can learn more, and they have your contact information now in the slides.

I would like to check in with Mireille. Mireille, as you know, is one of our partners in the recognition program and her audio didn't work properly earlier. So, Mireille is the Program Manager with the Patient Partnership Office at Health Standards Organization. I'll see if she has a few words and then I'll check back with Theresa. Mireille?

Mireille:

[0:21:33] Yeah. Thanks, Ioana, can you hear me?

Ioana Popescu:

[0:21:35] Yes, perfectly.

Mireille:

[0:21:38] Super. So, very simply, I don't want to take away from the presentations, but I just wanted to really emphasize on behalf of my colleagues at Health Standards Organization and Accreditation Canada, just a big thanks and congratulations to the teams, and emphasize how valued and important it is to share leading practices like the ones you're sharing today, and sharing them broadly like we are doing through this webinar. And thanks to all the participants who are taking the time to listen and learn.

So, as we teach the support organizations in developing capacity for good people-centered care and engagement, the how to very often is fuzzy. And I'm sure by listening to these illustrations and stories that are our understanding and our capacity to support good engagement practices increased. So thanks, and I look forward to hearing more.

Ioana Popescu:
[0:22:38] Mm-hmm. Thank you, Mireille. Let's see if we have Theresa back on the audio.

If not, I would like to remind the participants that we welcome your questions in the chat box. We have collected the questions that you included in the registration form. But maybe in the interest of time, why don't we turn it over to the next group of presenters. And I will remind you, please enter your questions in the chat box if you have any.

Joining us next are our colleagues from the BC Children's Hospital, Cathy and Leslie.

Cathy Masuda:

[0:23:21] Okay. My name is Cathy Masuda, Quality and Safety Accreditation Director for BC Children's Hospital, and Leslie.

Leslie Louie:

[0:23:28] And I'm Leslie Louie. I'm the Family Engagement Advisor at Sunny Hill Health Healthcare Center for Children. We're a program of BC Children's Hospital.

Cathy Masuda:

[0:23:38] So, Leslie and I are honored to present patients view to you and the journey on how we got to this point. Can I move my next slide? Our health authorities, provincial health services authority, PHSA, believes in the importance of talk about issues that could cause harm and how to stop issues from occurring. This is the culture of safety we want to create.

Since only about five to 10% of patient safety events are reported, PHSA wants to dig deeper and know what else should be reported. We have a province-wide web-based reporting system called BC PSLS; it creates some opportunity for shared learning by looking at report trends and enables staff to report anonymously.

[0:24:25] In 2007, BC Children's was involved in research called the Bedside Observer Project. This was a precursor for Patients View. Patients and families were seen as an untapped resource in identifying and reporting patient safety events. They have a unique perspective as they are a constant observer in their child's care journey, and they can also identify and provide information that may otherwise go undetected or unreported. It was the Research Team's goal to design and implement a system to promote patient safety by engaging the PSL Assess System in a new and innovative way.

So, over one year, 544 families were interviewed and enrolled in the study. 59% of these families reported concerns. Of the 321 reports, over half of these events were actual patient safety events, and the most common event reported was miscommunication between staff. And then, interestingly, 81% of parents actually volunteered and provided contact info in order to participate in future efforts to improve patient safety.

This research validated the tool and process which demonstrates that families are capable and reliably able to identify and report legitimate patient safety events. To translate this research into action, in 2012, the PSLS team and task force launched the pilot project on one inpatient unit, with support from senior leadership, patients and families. We used an innovative face-to-face patient and family engagement model, and we selected eight volunteers, oriented them to the role and deployed them to seek the patient's view.

This name was actually chosen with input from patients and families, clinical staff, and quality and safety leaders. So, patients and families were who were to be discharged within 48 hours were interviewed and info was inputted into PSLS. We had a number of indicators to measure to whether – we had a number of indicators that measured to determine whether the pilot project on one inpatient unit was a success, and some examples include process measures, family participation rate, validity of reports, outcome measure was all the improvement initiatives as informed feedback from patients view. And a couple of balancing measures were the number of reports related to patient safety and number of complaints to patient's care quality office.

[0:26:41] Feedback from patients. The reports informed quality improvement initiatives. Some examples are changes to the MRSA screening policy. You can go to the next slide, please. Standardized approach to post-op pain control and teaching. Another one was a process for calling back families to the bedside for procedures and rounds with healthcare professionals to improve information transfer. And since they're the constant in their child's life, they should be part of the handover team.

Some key findings from the pilot project included patients and families are more than happy to be invited to give feedback on patient safety. Face-to-face engagement with families was very important to facilitate reporting. And Patient’s View feedback can inform and validate quality improvement work. The pilot project success caused it to spread to other areas within BC Children's Hospital. So, emergency department with patients’ stay greater than four hours. our pediatric intensive care unit, our medical surgical inpatient units, and to the oncology hematology, bone marrow transplant program.

[0:27:48] One barrier to using the volunteer model was a high turnover rate of volunteers to pursue academic goals, and also moving on to paid work, which caused inconsistent number of Patient’s View reports. We abandoned this volunteer model and currently work alongside our new Knowledge and Innovation Department to recruit student group placements from specialism nursing or medicine health science programs. We also created standard work for students to meet the needs of the unit and to promote independence so they would access discharge binders and then they would just interview appropriate patients and families.

At the bedside, they would introduce themselves and invite families to share any safety concerns. They could either fill up the survey on their own and participation is voluntary and information is anonymous.

Quality and safety leaders then review the reports generated by PSLS, and feedback is used to action plans and plan accordingly for quality improvement projects. This new student group model provided reliable info and consistent number of reports due to consistent placement.

[0:28:57] So, patient. Next slide. Patient's View has been shared nationally and internationally. In 2016, we worked alongside a pediatric ward at Victoria General Hospital. They utilized a volunteer crew of eight nursing and two medical students to engage families three days a week, and now they want to spread to other sites such as pediatrics in Nanaimo and the emergency department at Victoria General Hospital.

Next slide, please. We had the opportunity to look at our current process and workflows and how to improve when we moved into the new Tech Acute Care Center. One of the largest numbers of patient safety concerns reported by our families at BC Children's Hospital is miscommunication among staff and miscommunication between staff and patients, which led to the whiteboard's plan for every patient room and the New Tech Acute Care Center.

It's a communication tool with the patients and families where they can write down names of each of their child's physicians, nurses, and other health professionals, any plans for the day, discharge information, scheduled treatments, and any questions that they may have. And prior to the move, the staff tested the use of the whiteboards and daily received feedback from patients and families to make appropriate changes to the whiteboards.

This large-scale change is a similar approach towards improving communications with patients and families to ensure that we're all on the same page. And the benefits and importance of this was reinforced by speaking with families and reviewing the feedback of Patients View. **[0:30:41]** So, a Patient's View interview just takes a few minutes to complete. Patients and families provide safety concerns related to any medication problems, complications of care, equipment problems, miscommunications between staff and miscommunications between family and staff. Positive feedback is also welcome, and we receive a lot of that as well, and we relay that to the staff.

However, if there's any other concerns that require more attention, we encourage the patient and family to talk to their assigned nurse or charge nurse. And then if they're unhappy with the response, information about the patient care quality office is provided to them.

So, what did patients and families tell us? Here are some examples of what has been inputted at BC Children's Hospital. For example, a nurse hung a bag of meds for IV that my daughter was allergic to, despite the large sign on the door and an allergy warning on her bracelet. An example at BC Women's Hospital was information was not sufficiently shared amongst staff, especially around shift change time. I almost got a duplicated test, but the mistake was caught on time.

If you can go to two slides forward to family satisfaction, please. And Leslie, I will pass this on to you.

Leslie Louie:
[0:31:58] Thanks, Cathy. I just wanted to say that patient- and family-centered care is one of the first priorities for BC Ministry of Health in terms of their strategic plan, and at BC Children's Hospital and Women's Hospital, our vision is to develop a culture where meaningful engagement with our patients and families is at the forefront of everything we do. Our aim is to learn from our families, to develop positive change, improve our partnerships and find solutions, and reduce and eliminate the gaps that we see. And Patient’s View is just one of the initiatives that we are taking at BC Children's Hospital to involve family feedback.

The importance which has been stressed before around communication, dialogue, connection, that can really only happen if we are using tools that are very specific and dedicated to gaining that feedback from our families. And that's one of the important things that Patient’s View does, is gives a specific number of questions that families can be asked. And as Kathy mentioned, families are engaged and are very happy to provide any type of information, both positive and negative, in terms of how we can improve our programs and services at Children's Hospital.

So, I guess we'll just talk a little bit about our next steps. Cathy?

Cathy Masuda:

[0:33:32] Yeah. So, we've come a long way since the Research Bedside Observer Project and also the pilot project on a single unit at Children's that happened in 2007 and 2012. The success at BC Children's has influenced great interest in other areas of the Health Authority. In 2016, BC Women's Hospital and BC Cancer also adopted Patient’s View. And last year, BC Mental Health and Substance Abuse Services did as well.
[0:34:01]
So, currently the program is at four PHSA locations. This is exciting, and we hope to expand to other areas within PHSA, such as Sunny Hill Health Center. So, this just demonstrates that patients and families is just one source of experience and expertise that has previously been ignored, which is what we want to change, and because we all know that they're a valuable resource for learning how we can continually improve. Thanks for listening.

Leslie Louie:

[0:34:29] Thank you, everyone. Are there any questions for Cathy or myself?

Ioana Popescu:

[0:34:35] Actually, there is a question. Thank you both for the great presentation. We, we all appreciate it. One question that I'm gonna ask you first, and then the AHS Team too, came from [Esha 00:34:44], who talks about that often patients are considered as a homogenous group and wondering how do you include the different social determinants, or how do you adjust the survey to adapt different needs of different populations?

Cathy Masuda:

[0:35:03] So, the question was how do you adapt the survey to the specific needs of the patients and families?

Ioana Popescu:

[0:35:09] Let's think language, or culture, or even physical needs.

Cathy Masuda:

[0:35:15] So, what we do have is that when our students go and approach the patients and families, they provide them the opportunity to actually input the survey on their own or they can come back. Or what we found very important, was that – and beneficial – is that face-to-face conversation with them and that dialogue, because they create that positive environment for them to do so. For those families where a language barrier exists, we welcome and invite a translator, as needed, but we would have to schedule that in advance.

[0:35:48]
So, when we do approach them and they demonstrate that they need a translator, then we'd have to schedule another time for them to come back. But usually, we have only 48 hours to do the interview because they're going to be heading out for discharge, so we want to get that done as soon as possible.

Ioana Popescu:

[0:36:06] Okay. Thank you.

Leslie Louie:

[0:36:07] We're working – we're also working closely with provincial language services to use telephone translators as well, and we can increase the ability to provide the information in different languages that way. That's also just a growing project that we're working on.

Ioana Popescu:

[0:36:28] Fantastic. And, Kathy, what are you guys doing at AHS?

Kathy Kovacs Burns:

[0:36:32] Well, similarly, we do certainly have translation services available to collect real-time patient information. We definitely would have to be prepared. I mean, usually the unit managers can let us know what patients are speaking different languages and what languages we would need to follow up with.

The Unit X that Marian was talking about, we had a buddy who actually could speak several languages, which was really kind of nice. But, you know, you'd always have that kind of opportunity. So, I agree it is a bit of a challenge and you do have to be prepared in advance if you want to collect real-time patient data.

But for Indigenous Peoples, we have a Wisdom Council. Oftentimes, we can call up very quickly and, you know, even in some of the hospital sites there will be an office that has translators and Indigenous People available to consult with and have them join the patient advisors. So, yeah, it just depends, but it is certainly a challenge. Absolutely.

Ioana Popescu:
[0:37:41] Hm-hmm. Thank you so, much. Theresa. I wonder if you have any questions? This is all that we found in chat.

Theresa Malloy Miller:

[0:37:45] No, I don't have a question right now. Shall we move on to our next group?

Josh Myers:

[0:37:50] Hi, everybody. So, it's Josh Myers here, Director of Patient Experience at Fraser Health, and we've got Terry Brock, who's a Regional Social Work Practice Leader at Fraser, also working in our professional practice department. And we are very happy to be here, So, thanks for having us.

Terry Brock:

[0:38:07] Yes, thanks for having us.

Josh Myers:

[0:38:09] So, at Fraser Health, maybe I'll just set the stage a little bit in terms of who we are. So, we are a fairly large health authority in BC that provides services to more than 1.8 million people. We have 12 acute care hospitals, almost 8,000 residential care beds. We have about 27,000 employees in 3,000 positions. And we serve, for those of you that are familiar with the lower mainland, we serve a geographical area between Burnaby and Hope, which is over 100 kilometers between those two locations. So, it's a fairly large geographical covering, and then also a fairly large population base.

So, the current slide I'm showing you now is just to sort of situate this work within a broader provincial context. And our partners at BC Children's will be familiar with this. Essentially, over the last several years, we've had the opportunity as a province to actually in a very coordinated and systematic way we've implemented provincial patient experience survey tools. So, the latest, over the last couple years we've implemented those in acute care, residential care, and just recently in our emergency departments across the entire province. That's a really, really well sort of structured process that we have already in place that captures patient experience data that we're kind of building off of.

[0:39:37] However, what we realized and what we were being told in our conversations with both patients and families at our regional pack level, but then also staff, is that where the gap was, is really having that data and information at our fingertips soon and in real-time. And then being able to actually use that data in a way to sort of almost support service recovery or to be able to support improvements quickly. So, we tried to create a – I think we've been successful in creating a tool that is a nice sort of companion tool to the provincial survey, but just provides a more flexible approach to collecting real-time data in a way that frontline staff are able to engage with quickly and are able to use to make a meaningful difference to patients and families while they're still in our care.

So, we started this work in 2017. We've been working with our partners at Cree Technologies to develop a tool. And we worked with our Regional Patient Advisory Council, which is a council of patients that comprises about 12 patients who are from our various communities. And they, as well as our Patient Experience Department and Cree Technologies came up with a tool and a series of questions that we felt comfortable trialing on 35 units across the organization in May of 2017, with the goal of providing patients and families an opportunity at the bedside to provide us with real-time feedback.

And so, we've, we created it as an electronic survey and Terry will show you what that looks like in a moment. We went through a pretty rigorous process of evaluation with our early adopter group. They provided us lots of great feedback, and so did the patient advisory councils, both at the regional level and our local patient advisory councils. And we got to a place where we were able to launch a final product to the organization in November of 2017.
[0:41:42] And just to give you a sense of where we're at today, so since November of 2017, we are – I'm not really sure why our slides are moving around here. We are live in 13 facilities. So when I said 12 acute, we actually have one outpatient surgical facility that's also included. So, we're live there at every single one of our sites, and they are at different degrees of implementation, but we are live at every single one of our acute care sites, and we're really proud of that.

We're at 10% implemented in home health, and that's the group that we're focusing more specifically on now. We're getting ready to launch in primary care as well as residential care at the end of the summer. So, by the Fall, this survey will be available in every single one of our service delivery areas.

So, what I'll do now is I'll hand it over to Terry to just give you guys a sense of what the survey looked like and how we're operationalizing it at Fraser Health.

Terry Brock:

[0:42:36] So, the survey itself is an electronic one that is hopefully easy for people to access when we have it presented to them electronically. There are a couple ways the survey can be accessed by some providers, is that they can they can pull it off from the web. They can pull it off from a QR code. And also, there's the ability for the survey itself to be emailed to patients and families, if they wanted to do it at a later time. The survey itself has been translated into five different languages, and the languages themselves were the ones that were the five most translated languages in our health authority: Punjabi, Chinese, Korean, and the like.
[0:43:16] So, this is what the login screen looks like when people come to the survey. They log in here and then they are taken to the survey, which looks like this. So, if you notice, we don't have a large survey. What was happening here is we did a large environmental scan of national, international tools and lots of existing surveys within Fraser Health itself. We crossmatched across, I guess, crossmatched with the top concerns with the Patient Care Quality Office, and we – the intent was to keep this as a short survey, hoping for the fact that people could complete this and make it easy for completion. And also, then it allows us to kind of get through the survey and we can have access to the data. Now, the bonus of having the survey in this electronic format, is the data and the responses after they're complete, are accessible immediately. That okay?

Josh Myers:
[0:44:10] No, that's perfect. So, thanks, Terry. So, the other thing that I'll mention is just when we were evaluating the survey, we were also evaluating an operational process along with it. So, as Terry mentioned, there's an opportunity to email the survey. There's an opportunity for patients to pull it up on their own devices using a QR code or a link. But then we also had sites

that really wanted to trial a process that includes volunteers circulating through the unit. And we did find that that particular operational process happened to be the one that generated the most responses, so a lot of our acute sites are kind of rolling with that process. So, similar to our partners in AHS.

And that's been giving us a lot of really rich data. And in our outpatient facilities, home health and primary care, are coming up with other operational ideas like <indiscernible 00:45:01>, using the email function, etcetera. So, we just wanted to create a tool that provided as much diversity in terms of operation, like as much a different ability to sort of operationalize as possible and so that the teams could work within their context to do what they thought would give them the best return in terms of that feedback.

[0:45:22] What you see here is just an example of what one of the sort of reports look like. So, as soon as a patient completes a survey, the data's immediately available at the fingertips of the managers.

And unlike the provincial survey or our PSLS data or patient care quality office data, which tends to go to a senior manager, and then it's up to that person to sort of trickle down the feedback. This particular tool is really meant to be frontline-driven and frontline-owned. So, the frontline staff and the managers are the first people to actually get access to this data, and then there's escalation processes that they can go through to actually escalate up. But at the end of the day, we wanted them to have immediate and free access to this information as it was coming in.

So, this is what one of the reports looks like. And we'll show you – we'll give you an example of how teams are actually using this information in a second. This is just a quick example of some of the open-ended feedback that we receive. And this is where we really find we get a lot of rich data, is in the open-ended questions. And we also included, as you probably noticed back there, an opportunity for people to actually comment on the positive experiences that they've had, because we really want to – we wouldn't want to reinforce positive deviance and we want to reinforce the really good work that is going on in our organization, as well as trying to pay attention to areas for improvement.

So, just to give you an example of a couple teams that have used this survey and what they've done with the data. So, this is Ridge Meadows Hospital, or their rehab unit. They were one of our early adopters, so they've been collecting data now for almost a year, and they've had a really good opportunity to kind of look over the course of several months what some of the themes and patterns are of their data.

[0:47:02] And I just highlighted where you'll see always. So, that means that with that particular question, 29% of the patients would've responded always to that question. So, what this team thought of is, you know, we should have – we really need to be focusing on, you know, making sure that our patients and families are actually always feeling like they're informed about their care, always feeling that they're a part of deciding to plan for their care, especially in a care context like rehab.

So, what they were trying to do is, is trying to actually increase those always numbers. And they're actually also getting feedback around, you know, qualitative feedback around the fact that they could have been doing a better job keeping their patients informed about their care and actually involving them about their care and informing them about the plan for discharge.

So, they took that information and they created the Rehab Journal. So, they used the data that they collected over several months, and they translated that into a package or a passport that allowed for more clear communication and a centralized place for their rehab patients, families, and the staff to be able to start doing this care planning and communication in a better way to try and help improve those scores.
[0:48:20] So, that's one example of how our teams have been using the data. Another one is our Rural Columbia Hospital Surgical Program. Rural Columbia is our major trauma center and they have four surgical units. They also recognized, or were told by patients and families through the survey, that they weren't feeling prepared for surgery. They weren't feeling prepared for their discharge home. They weren't feeling like they were a part of their care planning. And for these particular units, that was obviously concerning. So, they took that information and they developed a package of material, which they call Recharge for Discharge, and it was a combination of a couple different initiatives. One being that they refresh all of their surgical material, pre-op and post-op through our Patient Education Department, and then they also put their staff through health literacy training and teach-back training to help them not only have more accessible patient education material, but then also have the skills and tools to be able to do knowledge translation with patients and families in a more accessible way.

And this is what they noticed. And I think what you'll see on Q – so Q3 is from last year. This is what they noticed. This is the feedback that they received. So, they were getting 52% always for questions like how often do we keep you informed about your care? 54% always, or 56% always with whether they were involved in planning for their care, and then really low always responses for whether they felt like they were prepared to go home.

And what you see in Q1 of 2018-19, after the implementation of the Recharge for Discharge material, is a fairly significant increase of patients and families saying very often and always to those questions. So, they're really proud of that work and that's work that they've actually since presented on a couple of occasions.

So, just really quickly, in terms of the strengths, we're getting really encouraging response rates, as Terry mentioned. The fact that it's short and snappy and there are multiple ways to actually complete the survey has been a strength. It's available in six different languages. We also have given the teams the ability to add up to six customizable questions in their care area. So, everybody asks the same core questions, but if you're in rehab, or pediatrics, or surgical, or home health, and there are different questions that you want to ask specific to your unit or your program, they're able to add six customizable questions.
[0:50:39] The data that they're getting they’re finding quite meaningful and they're able to get their hands on the results of this data in a timely way, which has improved frontline engagement with the feedback that they're receiving.

Just really quickly, these are some testimonials from the folks. I think this is our early adopter group. Once they were done with the process of helping us create the final version of the survey, this is some feedback that they gave us about the benefits of the survey from a staff perspective. This feedback is actually from mostly frontline staff. So, when you get frontline staff who are this engaged in quality improvement, in patient experience measurement, I think we see that as very positive. And there's a huge sense of ownership at the frontline about the information that they're getting, and a huge sense of ownership about taking that information and translating it into quality.

And I guess the last thing I'll mention, is just how engaged and involved not only our regional patient advisory council has been, but also our local patient advisory councils who routinely and regularly are given feedback and updates on how the local areas are performing on the survey. And then they're really involved in supporting teams like Ridge Meadows and Royal <indiscernible 00:51:53> Surgical in terms of designing quality improvement and implementation plans based on the feedback.

Terry Brock:
[0:52:00] So, I know that we're just bumping up probably against the end of our time, so we'll leave it at that and if there are any questions for us, we'd be happy to answer those.

Theresa Malloy Miller:

[0:52:09] This is Theresa. I'm back again. That was wonderful. What do you see are your next steps going forward?

Terry Brock:

[0:52:21] Thank you. So, a couple next steps. There are next steps in terms of implementation. We really have a pretty significant amount of focus right now in our province and our health authority around supporting primary care and healthcare in the community. So, we focused a lot of our attention, at least in the early days, with the implementation in acute care because of the resources that are there and because of just the care areas are quite well situated to do this kind of work while we're getting our feet under us. But our next priority this year will be really trying to integrate this work into primary care and link it with our ongoing priorities and strategies around primary care.

So, that's one. And then the other one is just looking at kind of doing a PDSA cycle on our actual survey itself. You know, we've had feedback about whether it should be a four-point Likert scale, whether it should be five, whether it should be ten. Are we asking the right questions? You know, we've had lots of feedback like that. With being implemented since November, we're bumping up almost to a year now this fall, so I think at the November mark, the one-year mark, we'll have an opportunity to sit down with our regional patient advisory council and some of our key stakeholders to have those kinds of questions and really think critically about and apply the sort of foundations of quality improvement to ourselves and whether there's any minor changes that we need to make to the survey itself to make sure that we're getting the rich data that we're after.

Theresa Malloy Miller:
[0:53:49] Great. Wonderful. Thank you. I'm gonna hand this back over to Ioana and we're gonna wrap it up. Thank you, everyone for sticking with us and being so patient. Over to you, Ioana.

Ioana Popescu:

[0:54:00] Yes, thank you to all presenters. We actually had a few other good questions that I think in the interest of time I will send to you by email, and I think I can get the people who asked the questions emailed from our registration list so you can get a few more answers for them.

Great presentations. It was good to see how a couple of organizations started with research and builder surveys, others started with a PDSA, and it's just fantastic to see how it grew in different ways in your organizations. I almost want to invite you again in a year to tell us how things are a year from now.

Janet has placed a survey on your screen, so if you can take a moment to answer that survey. While you do that, I will invite our guests from Healthcare Can and from HSO to see if they have any final closing comments. So, Jessica, first over to you.

Jessica:

[0:55:01] Thanks, Ioana. Just want to thank all three organizations and teams for being so open to sharing your best practices, your innovative practices, and your lessons learned as well because I think that those often are just as important as the successes. But certainly, you've had many successes, so thank you so much for sharing that with us and continuing to do such great work with involving patients and families in quality and safety improvements.

Theresa Malloy Miller:

[0:55:32] Great. And Mireille?

Mireille:

[0:55:35] Just a quick shout-out and big, big thanks to the patients and families and carers who have been involved with these initiatives. I know that very often they're giving up their time very selflessly and to the benefit of so many people. So, thanks to the patients and family members that that put their time into these efforts.

Theresa Malloy Miller:

[0:55:59] Yeah, right. A big thank you to everyone for joining us today for this exciting conversation. The slides and recording will be available on our website in about a week, and if you have any questions, don't hesitate to let us know. Here's our email address on our screen. Have a wonderful day and we look forward to crossing paths again soon.

Good-bye everyone.

<End of recording>