



# FIRST

Do No Harm

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## Implementation of a Standardized Communication Process for Clinicians and Patient Care Staff at Children's Hospital Boston

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**Situation:** It is widely agreed that communication failure is a significant threat to patient safety and quality of care. In 2005, the primary root cause of over 60% of sentinel events reported to the Joint Commission on the Accreditation of Healthcare Organizations was communication failure. Unfortunately, the majority of these events led to patient death. Further analysis revealed that in the majority of these cases, a care team member was aware of potential concerns with the patient's care, but was reluctant or fearful to speak up. <http://www.jointcommission.org>

**Background:** Many healthcare organizations, understanding this threat, are striving to improve communication among their staff. In an effort to increase patient safety by improving communication, in 2007 Children's Hospital Boston's Senior Clinical Leadership Committee (Chief Executive Officer, Chief Operating Officer, Director of Patient Safety and Quality, Chief Nursing Officer, Physician-in-Chief, Surgeon-in-Chief and General Counsel) set a corporate goal to *implement a standardized communication process including assertion, closed-loop and SBAR communication techniques across the organization*. These communication techniques are defined as:

**Assertion** – All members of the clinical care team should be confident to speak up, state concerns, an alternative point of view or course of action, even if the team member feels uncomfortable.

**Closed-Loop** - A team member makes a request of another team member by addressing them by name. That team member then responds verbally confirming that they understand and are doing what is requested of them.

**SBAR** – An acronym for a situational briefing model using structured communication.

S – Situation (head line)

B – Background (context, objective data, how did we get here)

A – Assessment (what is the problem)

R – Recommendation (what do we need to do)

The Senior Clinical Leadership Committee strongly affirmed their commitment to achieving this goal by attending an eight-hour training program led by a local patient safety expert along with 165 key healthcare leaders from the organization. This interdisciplinary group strongly believes teaching communication practices in isolation would not be successful without a foundation of strong leadership who exemplified the communication methods taught by incorporating them in their daily practice. Additionally, it was important to the program that the hospital staff were confident that the organization sincerely valued their input into decisions involving patient care.

The Effective Communication Steering Committee, chaired by a physician, nurse and a quality specialist was established in January 2007. This committee meets monthly to assure implementation of the goals below, and to continually evaluate, improve and assess the program's sustainability:

- Establish and sustain improvement in teamwork and communication
- Improve the content and richness of the dialogue among clinicians
- Increase reliability, decrease errors and harm
- Reduce conflict

A more time-manageable, two-hour training curriculum was created for our clinical staff by selecting the most salient features of the original program and incorporating facets unique to Children's Hospital. A major objective in developing this condensed program was creating and sustaining an environment where effective communication is embedded into the fabric of the institution's culture.

(Continued on page 2)



### CHILDREN’S HOSPITAL STANDARDIZED COMMUNICATION PROCESS

(Continued from page 1)

**Assessment:** Over nine months, close to 4,000 physicians, nurses, social workers, pharmacists, perfusionists, respiratory therapists, patient care administrators and other healthcare professionals from our institution have attended the training. Training sessions are facilitated by two specially trained leaders who also attended the eight-hour training; typically a nurse/physician or a nurse/technologist teach together. The program included didactic instruction followed by realistic practical scenarios allowing trainees to practice critical communication techniques. This training is now integrated into Children’s Hospital new employee orientations for physicians, nurses and interdisciplinary staff. All new staff members are expected to complete the training within three months of beginning their practice. Short-term, rotating resident physicians and fellows will complete the training in their first week.

Our early experience has demonstrated that a hospital-wide, committed training effort can achieve high penetration. Quantitative and qualitative data show that we are changing behavior, albeit slowly. Twenty interdisciplinary clinicians have been trained in observation to collect data for this initiative and have achieved >85% inter-rater reliability using a checklist-based, behaviorally anchored standardized tool created by an expert panel; it is designed to measure principles taught in the training session: assertion, closed-loop, SBAR and other communication techniques. Observational data are used for timely formative feedback at the unit level as well as for quality assurance by the Steering Committee. Observations are performed monthly on random days. Team communications assessed include: patient transfer/hand-off, CPR events, patient rounds, and patient procedures, e.g. central line placement.

Selected examples of preliminary data that were collected are presented below (Figure 1 and 2.) The red arrows indicate the months that training occurred. The explicit use of names and verbalizing adjustments in the patient care plan rose on average 76% (range 14-98) and 50% (range 60-100), respectively.

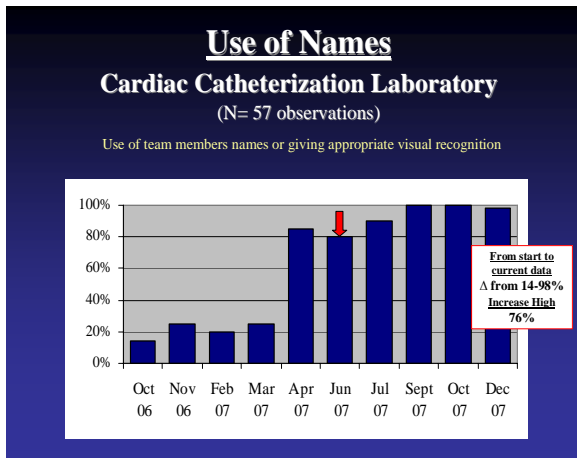


Figure 1

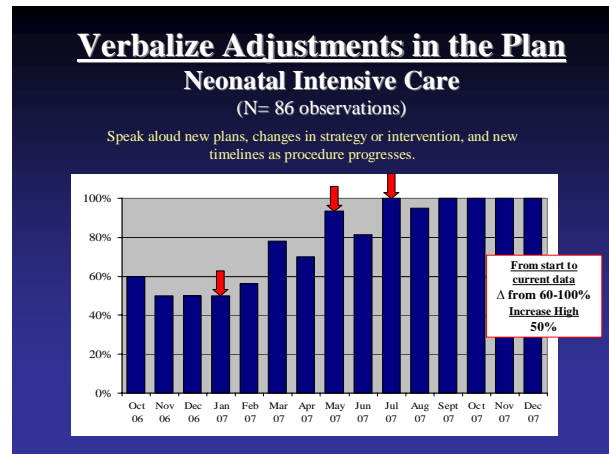


Figure 2

Qualitative data were collected via survey instruments to understand how clinicians felt about the quality of communication in their practice, both at baseline and after training. Preliminary data shows an institutional-wide perceived improvement in many aspects of communication in trainees’ clinical environments. The data also identified a persistent concern among trainees related to intimidation, or perceived intimidation, of senior clinicians as a barrier for consistently practicing assertiveness. Further emphasis on assertion and developing an environment that is receptive to speaking up is a priority for sustainability of the training. Additionally, there has been significant anecdotal data that the training has been of high quality and perceived to be important to their clinical practice. Another unanticipated positive outcome has been the implementation of SBAR communication by the staff, including providing feedback to each other, peer review, and in reporting adverse events.

We intend to continue to measure the impact of communication training on clinical care throughout the organization, however, we realize that measurement of this training on patient outcomes is exceptionally difficult.

**Recommendation:** We believe other institutions would benefit from using this framework to implement a standardized, organization-wide communication process to advance patient safety initiatives.



## Boston Medical Center Offers Comprehensive Interpreter Services

Being in an accident and rushed to the emergency room is something no one wants to experience. Feelings of anxiety and fear are natural, but can worsen if there is a language barrier between the patient and the caregivers. For many patients at Boston Medical Center (BMC), this is the reality.

Many patients who come to BMC are Limited English Proficient (LEP), making it difficult for them to communicate with doctors, nurses and hospital staff. The BMC Interpreter Services Department offers more than 150 languages; is available 24 hours a day, seven days a week; and helps patients interact with caregivers in their native language.

“We have one of the largest staffs of medical interpreters in the nation,” said Oscar Arocha, director of Interpreter Services. “Not even New York, Miami or L.A. has a hospital where an interpreter staff is larger than ours.” BMC’s Interpreter Services Department is also the oldest in the United States, originating 40 years ago when it was formerly Boston City Hospital.

Using the BMC Interpreter Services Department is easy and quick. When a staff member needs help assisting an LEP patient, he or she can request one of the 44 on-staff interpreters to assist, or use one of the 150 dual handsets around the hospital and connect to an interpreter in a matter of seconds. Once the interpreter arrives or is connected with the patient, the interpreter can help the patient understand his or her health status and make informed decisions. BMC handled more than 194,000 interpreter cases last year, compared to 29,000 cases 11 years ago, Arocha said.

BMC is always looking for new ways to advance the Interpreter Services offerings and recently installed and began using video interpretation services. “By being the first hospital in Massachusetts to provide wireless mobile video interpreting units, BMC is once again a pioneer in medical interpreting technology” said Arocha.

It is through the wireless video interpreting units that outside vendor Language Access Network can provide services known as MARTTI (My Accessible Real-Time Trusted Interpreter), who are trained medical staff interpreters. Staff members can turn on the video module and are connected to an interpreter provided by Language Access Network. The video interpretation is especially useful for patients who are deaf or hard of hearing because they can communicate using American Sign Language.

Cil Weekes-Cabey, a nurse manager at BMC, frequently uses the MARTTI services. “MARTTI gives me 14-hour accessibility, and that makes a big difference,” Weekes-Cabey enthusiastically explained. “It allows us to react to patients fast and easier, decreasing the anxiety often caused by language barriers.”

Video interpreting is just one way the Interpreter Service Department assists LEP patients. Other services include: written translation, video-discharge translation, departmental outreach and in-service training collaboration.

The next improvement in the department is to allow in-house interpreters to offer video interpreting using the same mobile units used for the Language Access Network. This will help reduce the waiting time for an interpreter and will also help the department serve more patients.

For more information on BMC’s Interpreter Services, contact Oscar Arocha, Director of BMC Interpreter Services at 617-414-7204, or [oscar.arocha@bmc.org](mailto:oscar.arocha@bmc.org).

*Thank you to Oscar Arocha (BMC Interpreter Services) and Maria Pantages (BMC Corporate Communications) for contributing this article.*

**PCA Philosophy**

**Even if the standard of care is upheld, in the spirit of quality care and patient safety, almost always there are opportunities for improvement.**



## Fairview Hospital's Focus on Sepsis

Fairview Hospital undertook an in-depth study of their performance in meeting the "Surviving Sepsis" guidelines published by *Critical Care Medicine* in 2004.\* The results of the study, conducted July to November 2006 were used by the hospital to formulate specific goals to improve recognition and management of sepsis. Fairview conducted a follow-up study in March and April 2007, and noted significant improvements in all areas of sepsis identification and management, including more frequent use of lactate levels to aid in diagnosis; decrease in median time to blood cultures; decrease in median time to antibiotic administration; earlier and more frequent placement of central lines; more aggressive management of septic shock; and improved medical record coding and documentation. Here are some of the highlights of the Fairview initiative.

The Fairview "Sepsis Team" developed a sepsis screening tool for use in the ED and on inpatient units. A wall poster outlining the guidelines was developed and is displayed in the clinical areas. A video learning module for nurses on severe sepsis was purchased. A physician was designated as lead educator for the ED staff; this physician and another colleague have pursued training in ultrasound guided CVC insertion. The team worked with lab staff to obtain equipment for immediate incubation of cultures waiting transport to the off-site lab. "Stat" Gram stains are now done at the Fairview lab.

Fairview endorsed the following performance objectives for sepsis care:

- ◆ Early recognition of the high risk patient, with lactates in all patients meeting sepsis criteria.
- ◆ Hemodynamic monitoring begun within 2 hours in patients with severe sepsis/septic shock.
- ◆ Cultures and broad-spectrum antibiotics within 2 hours of presentation.
- ◆ CVP>8; MAP>65; ScvO<sub>2</sub>>70% within 6 hours of presentation.

- ◆ Corticosteroid prescribed for patients requiring vasopressors.
- ◆ Achieve and maintain median glucose level <150 within 24 hours of presentation.

To improve teamwork and coordination of care, the Fairview ED staff and the inpatient service have met on a monthly basis to discuss relevant issues and hear presentations from guest speakers. On weekday morning rounds, nurse clinicians and the hospitalist specifically address each patient's risk for developing sepsis. A "nurse-initiated" chart identification process was started in the ED for patients meeting SIRS criteria: a red label stating "possible sepsis" is attached to the chart.

The outstanding work of this small community hospital at impacting sepsis should be an inspiration to other facilities. Fairview identified a need to focus on the diagnosis and treatment of sepsis syndromes through an in-depth study of their patient population, developed and implemented a plan, tracked results, and are continuing to refine their program.

\*Dellinger RP, Cartlet JM, Masur H, et al: Surviving Sepsis Campaign Guidelines for Management of Severe Sepsis and Shock *Crit Care Med* 2004; 32: 858-873.

*Fairview Hospital is a 25 bed critical access hospital, located in Great Barrington, Massachusetts. Fairview is affiliated with Berkshire Health Systems. Thank you to Dr. Robert Cella, Jr, Vice President Medical Affairs Berkshire Medical Center, Dr. Brian Burke, Fairview's Chief of Staff, and Dr. George Ritter, Director of Patient Safety and Healthcare Quality at Fairview for sharing both the results of the Sepsis Study and Berkshire Health System's Sepsis Screening Tool. If you would like a copy of the Screening Tool contact PCA at [barbara.watts@state.ma.us](mailto:barbara.watts@state.ma.us) or [jane.mihalich@state.ma.us](mailto:jane.mihalich@state.ma.us).*

### SQRs What Have We Seen?

PCA reviewed 65 Safety and Quality Reviews (aka Major Incident Reports) describing endoscopic perforations. The reports were submitted during the period May 2004 through July 2007. In all, emergent procedures accounted for 5 (8%) of the cases; 23 (35%) were elective and 37 (57%) screening procedures. 52 of the 65 patients required surgical repair and there were 13 reported mortalities. When reporting these events please include: indication for procedure; whether elective, screening or emergent; time elapsed from procedure to diagnosis; technique used; patient medications prior to and during procedure; treatment of complication (medical or surgical); cause of death, if applicable. If you have any questions about the types of endoscopic complications that you should be reporting as Safety and Quality Reviews, please contact PCA staff. In most cases, we consider an endoscopic perforation requiring surgical repair to be a Type IV "major or permanent impairment of a bodily function" under the PCA regulations, 243 CMR 3.08(2)(d). However, all deaths associated with this complication should be reported, even if there was no surgical treatment.



## Sophia Pasedis Named Chair of Board of Pharmacy

Sophia Pasedis, Pharm. D., R.Ph, member of the Board's PCA Committee since 2004, was recently appointed Chair of the Massachusetts Board of Registration in Pharmacy. Dr. Pasedis is the Vice President of Regulatory Affairs and Compliance at Ameridose and served as an Associate Professor of Clinical Pharmacy Practice at Northeastern School of Pharmacy and Massachusetts College of Pharmacy. She is a graduate of Massachusetts College of Pharmacy and Xavier University School of Pharmacy where she received her doctorate degree. In addition to her pharmacy practice and service as Chair of the Pharmacy Board, Dr. Pasedis is a member of the National Association of Boards of Pharmacy and numerous national and state pharmacy organizations. Dr. Pasedis is the recipient of an impressive list of awards from The Secretary of The Navy during her civilian employment at SOWEY Airbase.

## 2007 PCA Highlights

- ◆ One of the PCA Division goals for 2007 was to improve the "turn-around" time for reviewing SQRs and providing feedback to the reporting facilities. Through changes in the Division's processes for intake and analysis of these reports, the Division was able to decrease SQR turn around time from 13 months to 1 month.
- ◆ With emphasis on establishing more productive relationships with health care facilities, PCA Division staff and Committee members visited 41 hospitals to either present programs or meet with hospital leadership over this past year. PCA hosted a peer review conference and a seminar for rehabilitation hospitals.
- ◆ The PCA sponsored Credentialing Expert Panel met frequently during 2007 and has formulated a proposed standardized framework for core credentialing. The Panel expects to complete its work in early 2008.
- ◆ In 2007, the PCA Division received 826 SQRs, a 5.6% increase over 2006 numbers. PCA reviewed these reports, using the National Quality Forum (NQF) endorsed list of *Serious Reportable Events in Healthcare* and determined that 214 (26%) of the 826 SQRs submitted described events that met NQF reporting criteria. The SQR reporting form has been revised so health care facilities can now indicate whether the reported event is one that is on the NQF list. (See NQF-endorsed™ Serious Reportable Events in Healthcare 2006 Update: A Consensus Report. Washington DC 2007.)
- ◆ Collaborative efforts between PCA, the *Department of Public Health* and the *Betsy Lehman Center for Patient Safety and Medical Error Reduction* to improve adverse event reporting systems state-wide were initiated in 2007 and will be a priority for PCA in 2008.

## CONTACT PCA

To be added to the PCA Newsletter and advisory mailing list, update hospital contact information, submit an article; request an SQR form; or obtain additional information, contact Sheila Rhea-Nobles at [sheila.rhea-nobles@state.ma.us](mailto:sheila.rhea-nobles@state.ma.us) or (617) 654-9896. Send mail to MA Board of Registration in Medicine, PCA Division, 560 Harrison Avenue, G-4, Boston MA 02118.



Commonwealth of Massachusetts

BOARD OF REGISTRATION IN MEDICINE

## Board of Medicine 2007 Annual Report

Look for the Board of Medicine's 2007 Annual Report at the Board's website: [www.massmedboard.org](http://www.massmedboard.org). The report provides insight into the work of all of the Board Divisions.