PREPARING PATIENT, RESIDENT, AND FAMILY ADVISORS TO WORK ON QUALITY IMPROVEMENT (QI) AND PATIENT SAFETY TEAMS

Quality improvement efforts abound in most health care organizations across the continuum of care. Whether you are utilizing lean methodology, the Plan-Do-Study-Act (PDSA) cycle, or a continuous improvement approach, there are constant opportunities for changes to be made that will improve health care processes, programs, and services. The delivery of health care can be complex and fragmented. These conditions present safety risks to the patient (or resident living in a long-term care community), and staff. Inviting patient, resident, and family advisors to participate in quality improvement projects ensures that improvements maintain or improve safety and respond to the priorities and needs of those most affected by the changes.

Benefits of Partnering with Advisors

Advisors influence quality improvement and patient safety in three significant ways:

- Health care professionals make fewer assumptions about what patients, residents, and families "want" and engage in more dialogue about what solutions are possible when advisors are members of quality improvement and patient or resident safety committees and teams.
- Advisors "see things differently," and will ask, "Why do you do it this way?" Health care professionals often realize there is no evidence-base or valid answer. This helps organizations let go of processes that don't work for patients, residents, families, clinicians, and staff and find better solutions that benefit all.
- Advisors challenge what's possible. Often, staff say, "we can't do it that way" or "our accreditors and vendors won't support this change." Having the voices and support of patients, residents, and families makes change within and outside the organization more likely than one might imagine.

Most of the areas undergoing change and improvement are ones that directly impact patient, resident, and family care experiences. Involving advisors in quality improvement teams is a best practice among leading patient- and family-centered hospitals and clinics, and resident-centered long-term care communities, especially in the very important area of patient safety. More organizations are including advisors on established Patient Safety committees or on process improvement efforts like medication reconciliation or in other efforts to eliminate errors. Some innovative health care organizations have asked patients and families, who have experienced harm, to serve as advisors to review events and prevent errors from reoccurring. Because the goal is focused on making care safer for others, some advisors see the organization's outreach to them and the presence of advisors in quality improvement and safety initiatives to be a strong statement of the organization's commitment to prevent further harm. While such inclusion can never rectify the difficult situation an individual or family experienced, advisors report that their participation has been a good experience because they know they are making a positive difference for others.

Helping advisors prepare for their participation in quality improvement and safety activities requires additional orientation and training beyond the standard orientation provided to all advisors. Without this additional support, it is more difficult for advisors to be effective and provide the perspectives and insights that are so crucial as processes undergo change and improvement.

Planning Ahead

Prior to bringing any advisor into a quality improvement or a patient or resident safety effort, the following questions need to be answered:

- **What is the role of patient, resident, and family advisors in a quality improvement or safety project?**

Recommendation: The best option is for any advisor to be a full team member. This means attending all meetings and having an equal voice in discussions and decision-making. However, based on a number of factors including the area of focus, length of commitment, nature of the project, or the advisor's preference, this may not be possible. Other roles can include: consultant to the project, ad hoc team membership, and guest presenter to share their relevant experiences and suggestions about improvement opportunities.

- **How many advisors do you plan to involve in the effort?**

Recommendation: Plan to include a minimum of two to three advisors, depending on the size of the team. This communicates a sincere interest in incorporating the perspectives of patients, residents, and families. It also broadens the viewpoint represented. It is difficult for one advisor to speak for all patients, residents, and families.

- **Are there any special skills or experiences that advisors will need?**

Recommendation: If the team is focused on a particular process in a specific service line or clinic, it is advisable to involve advisors who have had recent experience in that setting. (i.e., received services in the last 18 months from that clinic, hospital department, or long-term care community).

- **What is the timeframe for their participation?**

Recommendation: Both the time of meetings and the length of service on a committee should be considered carefully. In some settings, teams meet in the early morning hours due to staff and clinician schedules. This may not be the best time for some advisors to meet. If this is a new team, you should explore times and locations that work for the advisors as well as the other team members. If this is not possible, you may unknowingly limit your advisor participation. Some groups rotate meeting times to accommodate different schedules. After relationships have been established, allowing for call-ins can minimize barriers to advisor participation, if commutes are lengthy. Sometimes, a team may choose to meet for an extended period less frequently to accommodate team members' needs (e.g., a three-day workshop to review an issue and make a recommendation). Planning ahead and considering all team members' schedules can minimize conflicts that could prevent meaningful advisor participation and input.

Terms of service need to be thought about when adding advisors as members of ongoing, operational groups such as a safety committee or quality council. Advisors should have the same length of service as other members except for those individuals who serve indefinitely because of their position in the organization (e.g., Risk Manager or Quality Director). Make sure that the terms of service for advisors do not all end at the same time. By maintaining continuity as well as fresh perspectives, the group's effectiveness is enhanced.

- **Have the staff and clinician members of the project had any experience working with advisors in any capacity?**

Recommendation: If the answer is no, take time to orient the QI or safety team to the role of advisors and discuss any concerns they may have. This is often done before advisors have joined the group, especially in situations where you are adding advisors to an existing, ongoing group. Share positive stories about advisors working on other QI, safety projects, or other initiatives in the organization. Address any concerns and enlist the sponsors of the ongoing committee to share why this decision was made.

Plan ahead for time on the agenda for introductions and a brief opportunity for the chair and the new advisors to share what they hope will be accomplished. Having the patient, resident, or family voice in the room changes the dynamic and encourages others to broaden their views. Many clinicians have found the meetings that include advisors to be much more meaningful and inspiring during this time of tremendous health care change.

- **Who on the team will be identified as the champion/mentor for advisors?**

Often the team leader or chair assumes this role because of their influence on the group and their historical perspective. Both are useful during the initial integration of advisors, especially when integrating advisors into an existing group. Another helpful mentor for advisors is a professional in either the quality improvement department or the risk management department. This professional generally serves as a team member or as a resource to a particular project and is familiar with the team as well as the operational processes inherent in the project or committee.

Training Recommendations

As you prepare advisors to serve on a quality improvement or safety team, address the following areas in training/specialized orientation:

- Orientation on the quality improvement (QI) methodology used in your organization and any definitions and tools that are well understood and used by staff and clinicians. If other members of the team need this QI orientation, provide this training to all members of the team and not just the advisors. Common terms and definitions are listed later in this document.
- Background on the particular QI project, including review of the charter, purpose or aim statement; members of the team and their title, role, and expertise; and a summary of any data that was used to select the project.
- If this is an existing committee or project that is either ongoing (e.g., Quality Committee or Safety Committee) or a time-limited team that has been underway and is adding advisors later in their QI process, more information may be needed. Review with and provide advisors with documents or products generated by the group. This provides advisors an opportunity to actively and effectively participate.
- In preparation for joining a committee that is already established, update each new advisor about current topics that have been discussed and that will be decided at the advisor's first meeting. This allows advisors to have time to think about possible questions to ask, understand the issues, and consider new thoughts or ideas before the meeting. By meeting with the chair of the group and sharing their perspective prior to the committee meeting, the chair has an opportunity to frame the issue on the agenda can discuss how to handle the issue on the agenda. By being proactive, advisors can avoid being perceived as a roadblock to progress when the topic in revisited.
- Talk with advisors about the use of data in this group. The sheer volume of quantitative data in health care can be overwhelming, even for staff. It is important to clearly communicate the questions that are trying to be answered by reviewing the data. Let the advisors know that when graphs and tables of numbers are presented, it is always

appropriate to ask the question, "how does this graph and/or data chart answer a question we are trying to understand?"

- Set up a meeting with the Chair of the committee to meet advisors ahead of time and identify a staff or current advisor on the committee who can mentor new advisors as they begin their participation.
- Debrief after a meeting with the advisors as a way to gauge how they are feeling about the experience. This is a good time for them to ask any questions that may not have surfaced during the meeting. After the first few months, most advisors do not find debriefing in this way to be useful. This is a good sign that they feel like a fully functioning member of the group.

When an advisor has attended a special orientation to quality improvement, safety, and/or the context of a particular project or team assignment, the advisor should be able to answer the following questions:

- What is quality improvement and what tools or methods are used to improve services in the organization?
- What are key safety concerns, terms, tools, and methods for improvement?
- What is the team trying to accomplish?
- What is my role on the team?
- How will we know that change is an improvement?
- Who is my main contact for ongoing support and assistance?

Suggestions from Advisors Who Have Served on Quality and Safety Committees:

- Be a full member of the team. Your views and experience are important—share them.
- Let other members of the committee know if they are using language or acronyms that you don't know. Each organization has abbreviations that can be confusing. Often, staff and clinicians don't realize they are using "shorthand."
- Ask questions and encourage staff and clinicians to think about the situation from the perspectives of patients, residents, and families.
- If you are confused or the meeting is moving too quickly, let the committee know. In these meetings, all members are expected to actively participate which includes asking for an explanation when things aren't clear.
- Use your own health care experience as a reality check as new ways of doing work are discussed.
- Think broadly about others in the community and their different perspectives. How might the committee's conversation/decisions impact other patients, residents, and families?
- Share with the committee leaders and/or your mentor what support or resources you need to be an effective member of the team.

- Review materials before the meeting, if provided. Show up a little early and call if you are unable to attend.

Selection of Advisors for Quality and Safety Teams

As you think about involving advisors in quality improvement or safety activities, there are different levels of advisor engagement—both in terms of time investments and accountabilityfor achieved solutions and outcomes. Increasing the depth of engagement requires greater orientation for advisors and support from the organization as it concurrently provides advisors an increasing amount of influence and decision-making. Providing advisors with a variety of ways to participate according to their interests, time, and background helps ensure successful matches to organizational opportunities. Advisors who have had positive experiences participating on work groups, councils, or in ad hoc assignments find the challenge of being placed on a quality council or safety team an appropriate progression in their development. A brand new advisor should gain experience participating in less intensive activities prior to joining an ongoing quality or safety group. This offers advisors the opportunity to build their skills and develop a relationship with staff. You can make exceptions to this general guideline, if for example, an advisor has been employed in another industry as a safety officer or has experience working on quality improvement teams.

Tips from the Field

These are successful strategies used by organizations to enhance the process of bringing advisors onto quality and safety committees.

- Provide committee chairs or mentors with a checklist of topics to cover with new advisors.
- Anticipate that the committee will need some preparation, if they have not worked with advisors before. Providing them time to share concerns and get information and reassurance from the staff liaison or team leader is time well spent.
- Provide the quality or safety group a bio sketch and photos of advisors.
- For technical committees (e.g., Medication Safety Team), it can be helpful to match the advisor up with a pharmacist or clinician who can sit next to them during meetings to respond to any questions they have and provide follow-up after meetings.
- Consider inviting advisors to yearly safety or quality events (e.g., as seminar participants, guest speakers) as preparation for participating in committees at a later date.
- Arrange for new advisors to sit across from the facilitator of a group, so that they can see each other. When, they have something to add or a question, this placement makes it easier for them to be noticed.

Common Quality Terms and Their Definitions:

Quality. The concept of quality has two dimensions in health care: clinical or technical quality and the patient or resident and family care experience. Clinical or technical quality is defined by agreed upon evidence-based standards, which define the best health outcomes possible. A patient's, resident's, or family member's perception of the care experience defines quality. It is strongly influenced by their values, culture, and whether they felt they were treated with dignity and respect, provided useful information, and that caregivers involved them in decisions related to their care choices.

Quality Improvement in Health Care. The combined and unceasing efforts of everyone to make changes that will lead to better patient outcomes, better system performance and better learning. Improvement efforts generally involve the following three components: Use of data to

identify quality gaps, understanding a process, and involving a diverse or interdisciplinary team to work toward solutions to eliminate the problem or improve quality (Batalden, P., & Davidoff, F. (2007). *Quality and Safety in Health Care, 16*, 2-3).

PDSA. This is an acronym used to explain the steps used to test a change basic to any quality improvement effort.

Plan is the first step where the opportunities for improvement are identified through analysis of data, observations and team knowledge. During this time a test of change is planned.

Do is implementation of a small test of change.

Study is the collection of data and observation of learning from the consequences of the test to see if it resulted in an improvement.

Act is the step that integrates what was learned during the test of change into another cycle of change or refinement.

The PDSA cycle is continually repeated until the change has improved the selected outcomes and is ready for widespread implementation.

LEAN. This is an approach to increasing value to the customer by reducing waste in processes. It was originally used in manufacturing. In health care, LEAN uses the concept of waste to redesign work. The first change is to eliminate any work that does not provide value to the customer—defined as the patient. Waste falls into seven categories: defects, waiting, transporting, inventory, motion, extra processing, overproduction (redundant work) and people (the waste of a person).

Rapid Process Improvement Workshops (RPI). Using a variety of tools from LEAN, Six Sigma, and continuous improvement, these workshops are one to five day events where a team comes together to make rapid, immediate changes to a process or work environment. The group spends significant time in the workplace observing and identifying waste. A sponsor meets with the team at the end of each day to be advised on what changes or recommendations have been implemented and to mobilize resources to eliminate any barriers that would prevent the team from meeting the specific financial, operational, or clinical quality goals established prior to the RPI.

Six Sigma. This is another approach to improving quality through the disciplined use of statistical analysis to show what the process is capable of producing. A clear focus on achieving measurable and quantifiable financial returns from any Six Sigma project puts it apart from other approaches. The goal is a process that has zero defects. A healthcare example is the goal to have zero instances where a patient was given a wrong medication that resulted in permanent harm or death. Six Sigma and LEAN approaches are often used in combination.

Pareto Principle/Chart. This principle says that when identifying opportunities for improvement, it is important to understand the "vital few" that account for the largest problem (60% or more). Pareto created a way to display data that helps a group "see" which causes or issues are the "vital few." Many have come to refer to this as the 80-20 rule. An example of this is looking at medication administration errors that have occurred. By organizing the number of errors by the medication names, it is easy to see which medications are involved in the greatest percent of errors. Through a focused analysis of those few, solutions can be targeted to provide the greatest benefit.

Run Charts and Control Charts. Taking data and plotting it on a graph over time is a visual way to determine whether the changes made have resulted in an improvement. A run chart shows the individual data points in relationship to the average or median of all data collected (shown as a horizontal line on the graph). Because all processes have variation, a run chart helps display whether there is a positive trend in the outcomes or goals set for the improvement team. A control chart is a more rigorous statistical method of displaying data in a graph and can provide more precise information about the nature of the variation. Examples of data to display in these charts are number of falls, length of stay, and time from arrival to treatment in the emergency department.

Flowchart. This is a visual diagram that shows the discrete steps or tasks used to create a product or deliver a service. The word **process** describes any series of steps or tasks that are completed by a combination of people, materials, and machines. Depending on the scope of a project, the process can involve more than one person or department and may even span more than one organization. Examples of processes include admitting a patient to the hospital, seeing a patient at the clinic, and managing a referral to another provider and represent a series of steps and tasks.

Qualitative Data. This data is information that describes something. It can be observational or information gleaned through interviews or surveys. Patient satisfaction surveys are an example of qualitative data. While this data can be reported in numbers and percentiles and compared to others who use the same survey, it is based on what value a person places on their lived experience.

Quantitative Data. This data is information based on the counting of discrete items. For instance, number of patients undergoing a particular surgery or total number of patients who receive care at a clinic. Many times the raw numbers are then reported in percentages. For example, the percent of people that got an infection from being in the hospital. These numbers can report good outcomes or defects (things that went wrong and are undesirable results of a process).

Common Patient Safety Terms and Their Definitions:

Sentinel Event. Any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a patient (or patients), not related to the natural course of the patient's illness.

Root Cause Analysis. A systematic investigation that identifies the factors that resulted in a harmful outcome. Its aim is to identify what behaviors, actions, inactions, or conditions need to be changed to prevent recurrence of similar harmful outcomes and to identify the lessons to be learned to promote the achievement of better outcomes. ("Success" is defined as the near-certain prevention of recurrence.)

Rapid Response Team. A group of health care professionals who respond to the identification of a patient in a health care setting whose condition appears to be deteriorating without apparent cause. The goal is to identify the cause and take actions to reverse the patient's decline in health status. In many hospitals, anyone can initiate a rapid response team including patients and family members.

Healthcare-Associated Infections (HAI). These are the most common complications of hospital care. Significant harm can be caused by these infections. These infections result from inadequate safety for key hospital procedures or hygiene practices. The most frequent HAIs are surgical site infections (SSI), catheter-associated urinary tract infections (CAUTI), central venous catheter–related bloodstream infections (CRBSI) and ventilator-associated pneumonia (VAP). These infection types account for 80% of all hospital associated infections.

Medication Reconciliation. A process of comparing the health care organization's documentation of a patient's medication record with the medications the patient is actually taking. Many organizations are working on improving these processes to avoid medication errors or drug-to-drug interactions that can result in significant patient harm.

The definitions above have been adapted from the Patient Safety Network and the Institute for Health Care Improvement. You can contact your quality improvement staff for additional resources. More information on quality improvement and safety terminology or definitions is available at the websites listed below:

- **Institute for Healthcare Improvement** at www.ihi.org. Leadership organization for quality improvement in health care that has many resources and examples of successful QI projects.
- **AHRQ Patient Safety Network** at www.psnet.ahrq.gov/. This patient safety network sponsored by the Agency for Healthcare Research and Quality has patient primers on key safety hazards in health care and an extensive glossary of terms.
- **National Patient Safety Foundation** at www.npsf.org/for-patients-consumers/. The NPSF has many resources for consumers. The Lucian Leape Institute is supported by the NPSF and is a leader in promoting the inclusion of patients and families into patient safety improvement initiatives.
- **Consumers Advancing Patient Safety (CAPS)** at http://www.patientsafety.org/. A consumer-led, nonprofit organization, CAPS is dedicated to improving the safety of health care through partnerships and collaboration. The CAPS website provides both information about patient safety programs and tools for building consumer capacity for collaboration.
- **Patients for Patient Safety (PFPS)** at http://www.who.int/patientsafety/patients_for_patient/en. A global network of patients and consumers who work with other groups and organizations. The ultimate purpose is to improve health-care safety in all health-care settings throughout the world by involving consumers and patients as partners.

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