PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Teaching/learning packets engender culture change

Initiative involved nurses, physicians, therapists

The team of safety and education professionals at UPMC (University of Pittsburgh Medical Center) in McKeesport, PA, has taken a pre-existing vehicle — teaching/learning packets — used successfully by the nursing staff and adapted it to an interdisciplinary approach to improving its safety culture.

The initiative — which involved physicians, nurses, and therapists — has been so successful the hospital recently was among five national recipients of the annual John M. Eisenberg Patient Safety and Quality Award, given by the National Quality Forum (NQF) and the Joint Commission on Accreditation of Health Care Organizations.

In the award process, three specific interdisciplinary teaching/learning packets were recognized as an innovative approach to blend excellence in patient care and provider training in the design and implementation of solutions to complex clinical issues:

- **Keeping Each Patient Safe (by calling for help early — Condition C)**.

  This initiative provides a process in which professionals are empowered to activate a crisis team whenever a patient has a significant change in status.
- **Keeping Each Patient Safe (from falls and confusion)**.

  This initiative clarifies the interrelationship between risk for falls, recognition of the confused patient, the appropriate use of medications in the elderly, and the need to design and implement an appropriate strategy to prevent falls in the patient at risk.
- **Keeping Each Patient Safe (from hospital acquired infections)**.

  The initiative dedicates the institution to pursue excellence in infection control by addressing isolation, hand hygiene, antibiotic usage, diagnosis, treatment, and prevention of *Clostridium difficile,* and safe and effective central line placement.

It was in 2002, recalls **T. Michael White**, MD, senior vice president for value and education, "that for the first time, we understood we could take this great idea [teaching/learning packets] and apply it to the docs [attending, consulting, residents], the clinical nursing staff at all levels, pharmacists, and therapists."

The packets already were a proven tool on a more limited scale, says **Christina Benczo**, RN, manager for staff education. "The nursing education department had used the packets for a long time," she says. "You can teach from them, and the learner can also learn individually from them."

This new adaptation focused around Condition C, a concept developed by Mike Davita, MD, and Richard Simmons, MD, at the University of Pittsburgh Hospital. In the packet, it is defined as "responding to a situation that is seen as an imminent crisis, with the intent of intervening *before* the situation becomes irreversible." It goes on to say that Condition C "may entail calling a '333' before an actual 'arrest' situation results."

"The idea was: Why wait for a code if a patient is not doing well; why not call for help early?" White explains. "We brought back the concept, then we got the right people together."

White's team found in the first experience was if it understood the concept and got the right people together with the expertise to address it, the team could design a teaching/learning packet. "Central to writing the packet was to write it in our local language, in the terms of our institution," he says. In this case, the right people were the "code types"

— nursing leadership, critical care nursing, critical care physicians, residents, ED physicians, respiratory professionals, and anesthesiologists. "Buy-in was pretty easy," White adds.

However, writing the packet "was hard work," he notes. "We had to take the idea and put it into a language we thought the nurses and docs could relate to. Chris [Benczo] has a good eye for display, and placed humorous pictures in the right place."

The packet opens with instructions, followed by a list of objectives. It explains Condition C is a medical crisis, and based on a set of criteria (i.e., respiratory rate < 8 or > 36; new pulse oximeter reading > 85% for more than five minutes; acute loss of consciousness), it can be initiated by calling a "333." Later in the packet, the criteria are spelled out in detail, and a case example is presented.

White's team understood there was hesitancy among staff to call for help because it might be perceived as an element of weakness. "If you look closely at Chris' [White and another individual also wrote the packets] language, it communicates that fact that it's not only OK to call for help, but that you *must* call for help," he adds.

In fact, to not call for help "is now perceived to be a failure to rescue," says **Cheryl Como**, RN, senior vice president of patient services. "Our culture has moved to do this."

The message was spread throughout the various disciplines, and the new concept was implemented successfully within one month. "Everyone got a manila folder with the teaching/learning packet inside so they could take it with them," White notes. They also attended educational sessions.

"The nurses also had continuing ed classes," Benczo adds. "And all new employees get the packet."

The packets have had a marked impact, Como says. "Nurses were able to move from nursing the system to nursing the *patient*. With a single activation of a code, all the help they needed instantly appeared," she explains.

"We went from six codes a month and a survival rate of less than 50% to about 39 calls for help a month, where most patients survived," White says. "We might have slightly less than five traditional codes a month." His facility now is assisting a sister hospital with adopting Condition C.

It takes two committees to help UPMC stay on top of safety issues and determine which should be addressed by teaching/learning packets, he says.

"They are central to our processes here. One is the value committee; value is an equation here, where we recognize that we are in the business of providing value to our patients," White notes.

"The committee meets monthly; board, administration, staff, and nursing leadership come together to better understand how we are doing," he says. "Central to their efforts are measurable indicators over time with run charts, statistical process control charts, and so on."

Processes that are identified as out of control become natural targets for teaching/learning packets, White notes. "Or as in any enlightened institution, for all serious events, we undertake root-cause analysis. When we do, sometimes we see patterns among those root causes."

The other committee, the patient safety committee, looks at similar data, he explains. "But of course, they always have the patient safety perspective foremost in their minds."

While the team at UPMC McKeesport has identified common elements for success in its teaching/learning initiatives, it also has learned each element can unfold differently in different areas., White says. "For example, getting the right people together was more challenging when it came to Keeping Each Patient Safe from falls and confusion. We thought it was [only] about falls, but now we understand it's about falls, confusion [delirium and dementia], meds, and about strategies to keep the vulnerable patients safe. These light bulbs went on over period of time, but the right people for this are local, regional, and even international geriatric-type people; nursing; pharmacists; therapists; and of course, our physicians."

The team set out to address this issue at the end of 2003, with the packets materializing in March 2004. "We started to get this message out, and all of a sudden I understood after talking to some docs it was not working," White recalls. He realized he had to position falls and confusion as a medical syndrome. "Once that message started to get it out, everyone understood then that if it was something we could recognize, we could diagnose its cause, treat it, and prevent it."

White learned through this process. Among his learnings, he includes the following:

- Falls have the potential for significant morbidity and mortality.
- Falls don't belong to nursing; they belong to the team.
- You can't talk about falls without addressing confusion.

"As an institution, we are much better now. On the floors, you'll hear docs talk about delirium; the influence is robust," he says. ■