Patient and Family High Reliability Partnership Initiative
Fast-Tracks Boston Children’s Hospital’s Safety Journey

By Audrey Doyle

In 2014, Boston Children’s Hospital embarked on a journey to reduce events of preventable harm by embedding safety and High Reliability operating principles into its organizational culture.

Starting this spring, hospital leaders will invite patients, their parents and other members of their care team to join them on their quest to prevent future events through an initiative that makes High Reliability safety behaviors and error prevention techniques easy for them to understand.

The objective of the new Boston Children’s Hospital Patient and Family High Reliability Partnership Initiative is to encourage patients and their families to voice observations, opinions and concerns they may have regarding quality and safety at the facility, thereby helping care teams prevent errors from occurring, according to Yolanda Milliman-Richard, RN, vice president and associate chief nursing officer, Surgical Services.

“We learned through safety huddles and other anecdotal evidence that safety events and near misses were sometimes being detected because family members spoke up,” explained Milliman-Richard. “We developed this initiative to help all our patients and families feel comfortable speaking up if they hear or see something pertaining to their care that doesn’t seem right. Our goal is to eliminate preventable harm and errors, and we think this will help us do that.”

Soliciting Feedback from Patients and Families

A 414-bed pediatric teaching hospital of Harvard Medical School, Boston Children’s Hospital has long been committed to quality and safety and demonstrates this commitment through a variety of resources, several of them centered on patients and families. For example, a Family Advisory Council comprising staff and parents of current and past patients develops and promotes family-focused initiatives that affect quality of care, safety and the patient experience. A Teen Advisory Council consisting of adolescent and young adult patients suggests ways to enhance the quality and quantity of programs that affect them through self-advocacy. And a Program for Patient Safety and Quality composed of patients, families, clinicians, scientists, biostatisticians and administrative staff uses patient outcomes and reportable events data to help maintain practice standards and measure Boston Children’s performance.

The Patient and Family High Reliability Partnership Initiative is the hospital’s newest such resource. Developed by Boston Children’s Hospital’s High Reliability Safety Leadership Team, Office of Experience, Family Advisory Council and clinicians and staff, the initiative is a patient- and family-friendly version of the High Reliability Error Prevention Toolkit, an employee resource leaders had developed previously with HPI Press Ganey.

In 2014, Boston Children’s had begun collaborating with HPI Press Ganey to enhance its focus on quality and safety through a safety culture improvement initiative. An HPI Press Ganey analysis of past safety events had revealed that focusing employees on the safety behaviors of Speak Up for Safety, Communicate Clearly and Pay Attention to Detail would build and sustain an organizational culture that would drive advances in patient outcomes, safety and experience. Boston Children’s and HPI Press Ganey had developed the High Reliability Error Prevention Toolkit to teach employees how to practice these safety behaviors and their associated error prevention techniques, and had trained them in its use.

AT A GLANCE

- With the new Patient and Family High Reliability Partnership Initiative, Boston Children’s Hospital leaders are inviting patients and their families to help prevent errors at the facility by encouraging them to speak up if they have a concern regarding quality and safety.
- The initiative presents the Speak Up for Safety, Communicate Clearly and Pay Attention to Detail safety behaviors and associated error prevention techniques in language that’s easy for patients and families to understand.
- Data from the hospital’s incident reporting system showed the percentage of safety events and near misses staff had learned about from patients and families to be approximately 11.5% during one six-month period.
According to Julie Kirby, program manager, Nursing/Patient Care Operations, implementation of the employee toolkit resulted in the training of more than 15,000 employees in High Reliability tools and behaviors. As a result of the training and awareness of the importance of reporting safety events, Boston Children’s noted an increase in the reporting of safety events and near misses since training began, which has helped to identify opportunities for improvement.

Although the training was helpful for employees, the development team didn’t want to just assume it would be helpful for patients and families. “We knew from parents on our Family Advisory Council that when they’re here for a meeting, they feel like ‘speak up for safety’ sounds great and they’ll always ask questions and point out errors they may see,” Kirby said. “But when they’re here as parents of a sick child lying in a hospital bed, they’re in a different mindset and don’t always feel encouraged or comfortable speaking up.”

To determine whether the employee toolkit would give patients and families the tools they’d need to feel encouraged and comfortable speaking up, the development team showed it to focus groups of patients and families to gauge their understanding of its contents. When the team learned that the safety and High Reliability terms and phrases in the employee toolkit didn’t resonate as quickly with patients and families, they tweaked the descriptions of the error prevention techniques to simplify the concepts.

For example:

- “Cross-check” became “…if you hear something that doesn’t sound correct during a situation involving your child’s care, we encourage you to question any member of your care team to ensure that all information is correct.”
- “Escalate concerns” became “If you have a question that does not get answered or notice an unsafe condition, please feel confident in raising concerns to the care team or management in order to address them quickly.”
- “Ask clarifying questions” became “Any question you have regarding your child’s care is important. Keep asking questions until you understand the answers.”
- “Honor distraction-free zones” became “During certain high-risk situations, care teams need to be able to completely focus without any distractions, like reviewing critical information or preparing to administer medications or perform procedures. Care team members may ask you not to interrupt them while they are completing these important tasks that are so critical to keeping your child safe—please honor these distraction-free zones. You should always feel free to ask questions outside of these zones.”

By making these tweaks, the development team not only simplified the concepts, but also showed the focus group participants that their feedback was taken into account, noted Kirby. And because the team used language similar to that used in the employee toolkit, they ensured that the concepts would remain familiar to staff, which would aid in the toolkit’s sustainability, she said.

Soliciting Feedback from Staff

Although the new initiative is geared toward patients and families, the development team felt that sufficiently preparing the staff for its launch would be integral to its success. To gauge staff members’ willingness and ability to discuss safety issues with patients and families, the team conducted several staff focus groups.

One thing they learned was that many employees felt patients and families were already comfortable speaking up about safety concerns. To address this, the team showed employees comments from prior Press Ganey patient experience surveys as examples of where there was room for improvement in this regard.

The team also shared with the staff data from the hospital’s incident reporting system, which leaders had customized to track the percentage of safety events and near misses staff had learned about from patients and families. According to Kirby, for the six months prior to conducting the staff focus groups, the percentage of instances in which a patient or family had some involvement in identifying a safety event and informing care team members of the event hovered at 11.5%.

“That was powerful in getting staff on board with ensuring that all our patients and families feel comfortable reporting these events,” said Milliman-Richard. “It showed that if 11.5% of the time it’s a patient or family that’s bringing the event to our attention, chances are good that these events have happened more frequently but weren’t reported in our system because the patients and families that noticed the events were reluctant to speak up about them.”
The staff focus groups also revealed to the team that some employees were unsure how best to respond if a patient or family member did speak up about a safety issue. “It can be tricky to make the point to a family that we’re using this as an extra safety measure without making them feel nervous about their child’s safety,” said Kirby. “Our fear was that we’d roll out the initiative and a family would raise a concern or ask a question, and the staff would react negatively or not know what to say. Then the family wouldn’t feel empowered to speak up again based on that initial experience.”

To secure buy-in from the staff, the development team listed some of the scenarios staff members were most concerned about and asked a patient and family focus group how staff could best respond in those situations in a way that would both confirm the importance of the family’s voice in their child’s care and assure the family that the team is fully committed to the safety of their child.

Pointing out to staff how use of the initiative can extend beyond the hospital walls also helped secure buy-in. “Explaining that the initiative could be used to help improve patient safety and reduce readmissions—for example, for one of our tools, called STAR, or Stop, Think, Act, Review, to be used by parents at home if they need to prepare and administer complicated medications for their child—was a big part of getting staff to see how this can be applied in other settings,” said Courtney Cannon, vice president, Business Operations and Strategy for Nursing/Patient Care Operations.

**Safety: A Continuous Journey**

The new initiative was pilot-tested with staff and families in one of the facility’s inpatient medical units this past summer, and it was well-received, according to Kirby. When it is rolled out hospital-wide in the spring, it will be incorporated into a pamphlet that patients and families will receive on admission, and it will be available on GetWellNetwork, a solution that uses the bedside TV to engage patients and families in the care process. The development team also hopes to pilot-test the initiative in the hospital’s emergency department sometime next year. To gauge the initiative’s success moving forward, they plan to track patient experience scores and incident reporting system data.

One thing they’ll never do is demand that patients and families use the tools and behaviors. “This is an invitation, not a mandate,” stressed Kirby. “We’re not telling them, ‘It’s up to you to make sure we use two patient identifiers at all times,’ for example. We’re saying, ‘We’re inviting you to be part of the care team through this initiative, and if you want to join us, here are some tools you can use.’

“Reducing events of preventable harm is challenging for any organization,” she concluded. “By offering patients and families this opportunity to get involved in quality and safety, we’re adding an extra safety measure that’s putting the goal of becoming a High Reliability Organization within our reach.”