Rounding for Safety’s Sake: Family Centered I-PASS

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Disclosures

Dr. Khan has

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Dr. Baird has

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Drs. Destino, Patel, Khan, and Baird, and Ms. Micalizzi will

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Objectives

• Practice evidence-based techniques for patient/family centered rounds to increase patient and family understanding and engagement
  – Universal literacy precautions
  – Structured communication
  – Multimodal communication

• Articulate strategies to improve workflow, engage nursing, and capitalize on teaching opportunities for learners while maintaining the patient/family as the focus of communication in the room

• Identify strategies to implement or enhance patient/family centered rounds at your local institution
Overview

• Introductions
• What is patient and family centered rounds?
• Why bother with something new?
• How do we improve?
• What works? What can we improve?
• What can you do at your institution?
What is Patient and Family Centered Rounds (PFCR)?

Jennifer Baird, PhD, MPH, MSW, RN
Family Centered Care
to
Patient and Family Centered Rounds

- Multiple organizations call for family-centered processes of care
- Implications for safety, quality, patient experience
- Rounds with the family is one way to contribute to family centeredness

Patient and Family Centered Rounds

“multidisciplinary bedside rounds where both the patient and family are able to participate in medical decision making” Sisterhen LL et al. 2007

“.. [bedside rounds] will facilitate exchange of information... and encourage the involvement of the family in the decisions... In teaching hospitals...a lasting impression will be made on students and house staff.” AAP and Institute for Family Centered Care 2003
Interactive Exercise

Communication Pitfalls During Hospital Rounds (not necessarily PFCR)
Interactive Exercise

• Describe an experience with poor communication on rounds
  – Individual reflection for 3 minute
  – Pair-share for 4 minutes
  – Table share for 5 minutes
  – Large group shout out for 5 minutes
“The goal of patient-centeredness is to.... modify the care to respond to the person, not the person to the care.”

-Crossing the Quality Chasm, IOM
Why Bother With Something New?

Ongoing Challenges

Alisa Khan, MD, MPH
How We are Doing: Communication

- Parents and night-team residents lack shared understanding 45.1% of the time\(^1\)
- Parents reporting parent-provider miscommunications were 5.3 times more likely to report errors and 80% less likely to report top-box experience\(^2\)

“... They’re talking amongst themselves with you in the room. You’re trying to pick out what they’re talking about... They did ask me if I want to join rounds in the room, but now I think I would round outside the room because they are confusing... that’s what happens with all the talking.”\(^3\)

\(^2\)Khan et al. PHM Platform. 2016.
How Can We Be Better?
How Much Better Can We Be?

- Multicenter prospective pre-post study in 7 inpatient pediatric units across North America
- Staggered implementation and data collection from 2014-2017

- Primary Outcomes:
  - Medical Errors and Adverse Events

- Secondary Outcomes:
  - Family Experience
  - Round Processes
Harmful Medical Errors Fell 38%

*BMJ* 2018;363:k4764
Improvement in Family Experience

- Understood what was said on rounds
- Understood written updates provided
- Shared understanding of medical plan with nurses
- Nurses addressed family concerns
- Nurses made family feel an important part of healthcare team

% Top-box score

Pre-Intervention
Post-Intervention

* p<.05
Communication Process Scores

n=206 rounds encounters pre-intervention; n=278 post-intervention

* p<.05
How Do We Improve?

Key Components of Patient and Family Centered Rounds

Engaging the Family, Engaging the Nurse, Plain Language, Structured Communication, Written Communication, Teaching

Dale Micalizzi, AAS
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Alisa Khan, MD, MPH
Shilpa J. Patel, MD
ENGAGE the Family Part 1

Invite | Inside? | Introduce

• Invite patients and families to join discussion
  – Reinforces patient and family member roles as team members
  – Sit rather than stand, listen rather than speak

• Inside or outside room? Determine location

• Introduce team
  – Have patient and family member introduce themselves 1st

• Set agenda:
  – Time allotment
ENGAGE the Family Part 2
Concerns and Illness Severity

• START with opportunity for patient and family to raise **questions, concerns and state if their child is better, worse or the same**
  – Engages patient and family
  – Promotes development of shared mental model
  – May reveal discordant understanding
  – May offer an opportunity for explanation or revision of plan

• Ask nurse or other ancillary staff members for concerns as well
How do you encourage patients & families to speak first?

• “How do you think your child is doing?”

• “What are you most concerned about today?”

• “We have reviewed the admission notes and talked with the overnight doctors. What new concerns or questions have come up this morning?”

• “This morning, when I came in to examine your child, you mentioned you are concerned about ______. Is anything else concerning you?”
ENGAGE the Nurse
(and other team members)

• Consider
  – Work schedules
  – Culture and tradition
    • History of physician-centric rounds
    • Nurse as observer rather than active participant
  – Lack of inter-professional training
  – Length of rounds
Plain Language

Healthy People 2010 Health Literacy Definition

- Obtain, process, understand basic health information and services
- Make appropriate health care decisions (act on information)
- Access/navigate healthcare system*

*not in the Healthy People 2010 definition but functionally very important
Health Literacy of America’s Adults

78 Million Have Below Basic or Basic Health Literacy

Plain Language

Universal Precaution Principles

• Everyone benefits from clear information
• Many patients are at risk of misunderstanding, but they are hard to identify
  – “You can’t tell by looking”
• Higher literacy skills ≠ understanding
• Health literacy is a state, not a trait, affected by
  – Stress
  – Sleep deprivation
  – Pain
  – Context/disease
Plain Language

Quick Tips

• Common everyday language; “living-room language”

• Limit medical jargon (fever vs. febrile; medicine vs. medication)
  – If using medical words, explain them

• Slow down

• Organize into 2-3 key concepts: “chunks” of information

• Action-oriented language

• Focus on “need to know to do” vs. “nice to know”
Plain Language

• **Use and define** important terms that families are likely to hear elsewhere
  
  • “We are concerned that Johnny might have sepsis, which is an infection of the blood.”
  
  • “Johnny has an infection called pseudomonas, which is an infection that has become resistant to some types of antibiotics. Not all antibiotics work on this infection, but we will test to find one that does.”

• **Explain** what tests/treatments are and how they work
Plain Language

Numeracy

• Difference between what a number is and what a number means:
  – My child’s risk of getting a stroke due to SS Anemia in the next 5 years is 14%.
    • Is that high, or low? How do I lower it? If I lower it by 2% is that helpful?
  – My child’s WBC increased from 13,000 to 17,000 since yesterday.
    • Is that bad? What does that mean? When should it be checked again?
“There is one doctor I love ... uses the big medical terms, but then he explains it in plain language. “Well... her AST is up and ALT is down. What does that mean. John’s liver is not filtering, and the liver takes out the bad stuff. So when that number is high, it means the liver is not filtering enough.” Instantly – I didn’t have to go to medical school, he didn’t treat me like I was a dummy..”  
Patient and Family Centered I-PASS Family Advisor
Plain Language
A Word About Limited English Proficiency

• Population at risk due to impaired communication

• Not patient and family centered without interpreter?!?!

• Multiple options for interpretation
  – Short phrases
  – Eye contact with family
  – Use it!
Health Literacy Jeopardy

• Selena is a 16 year old female with no past medical history who presented last night with fever and respiratory distress.
  – Selena is a 16 year old healthy girl who came in last night with fever and trouble breathing.

• She was found to have a right sided infiltrate on imaging.
  – She had chest x ray which showed she had pneumonia, which is a lung infection.

• Her labs were notable for leukocytosis with a left shift.
  – Her infection fighting cells, which we call white blood cells, were high. We see this when the body is fighting an infection.
Structured Communication

I-PASS An Organizing Framework

I  Illness Severity
   — Getting better, getting worse, about the same

P  Patient Summary
   — Problem oriented
   — Ongoing assessment and plan

A  Action List
   — To-do list

S  Situation Awareness & Contingency Planning
   — Knowing what’s going on
   — Planning for what might happen

S  Synthesis by Receiver
   — Check-back: receiver summarizes what was heard, asks questions, restates key action/to do items
Structured Communication
I-PASS An Organizing Framework – ILLNESS SEVERITY

Wow! Your cholesterol has me really worried!
Gack!
Uh... you might want to actually look at the patient...

AND “SPEAK WITH THE PATIENT”
Structured Communication
I-PASS An Organizing Framework – PATIENT SUMMARY

seeing the forest for the trees

There it is. Thanks! Much obliged. Let’s go!

© John Atkinson, Wrong Hands

FEN/GI
Respiratory
CV
Dispo

Nutrition
Pneumonia
Discharge Goals
Structured Communication
I-PASS An Organizing Framework – ACTION LIST

• Summary of main action items from the plan
  – Orders, consults, studies, procedures
  – Timeline: today, this week, before discharge

• Follow-up

• Write it down!

My Plan for Today

My Name:                           Today's Date:
My Team:                           My Attending MD:
My Surgeon:                        My NP/PA/Resident:
My Nurse:                          My Respiratory Therapist:
My Case Manager:                   My Child Life Therapist:
My Social Worker:                  My Anticipated Discharge Date:
My Plan for Today:                 
My Questions for the Healthcare Team:
Structured Communication
I-PASS An Organizing Framework –
SITUATION AWARENESS/CONTIGENCY PLANS

• Problem solving *before* things go wrong

• If this happens, then...
Structured Communication
I-PASS An Organizing Framework – SYNTHESIS BY RECEIVER

“There are a lot of things to do when you go home. I want to be sure I have communicated clearly so can you tell me what we will be watching for over the next few days and what medications will be new.”

“We have discussed a lot this morning, can you tell me your understanding of the plan for the day”

“Just so I can check that I have explained things well, can you tell me what you’ve understood”
Health Literacy Jeopardy

• She was given a dose of IV ceftriaxone and admitted for further management.
  – *We gave her antibiotics called ceftriaxone through the IV for the infection.*

• This morning, her fever curve is downtrending, her WBC is down, her respiratory rate is slower, and we were able to wean her oxygen to 1 liter.
  – *This morning, she is doing much better overall. Her fever and white blood cell number are both down, which is good. Her breathing rate is better, and she needs less oxygen (1 liter).*

• In summary, this is a 16 year old female here with an infiltrate, who is improving on ceftriaxone and oxygen.
  – *In summary, Selena is a 16 year old with pneumonia, which is an infection of her right lung. She is getting better on antibiotics and oxygen.*
Patients prefer receiving messages from their health care provider with accompanying print materials / visuals.

Print materials, used as part of verbal counseling:
- Helps reinforce verbal messages
- Helps reduce cognitive load as brain capacity to process information is finite:
  - 7 digit phone number
  - Text and graphic material are processed separately
Written Communication

Word Choices Matter

Cross-Section of the Ear
Written Communication

Rounds Report

- Structured real-time summary of FCR takeaways for families
- Paper preferable to whiteboard
• Plan is to continue ceftriaxone, wean oxygen as tolerated, encourage oral intake.
  – Plan is to continue antibiotics, turn down her oxygen if we can, and encourage her to drink.

• She can go home when her fever is gone, she is breathing better, and she doesn’t need oxygen anymore. We think that could even happen tomorrow.

• Sound good?
  – What questions do you have?
  – I know we went over a lot. Just to make sure I’m doing a good job explaining, what is your understanding of why she’s in the hospital?
Teaching on Rounds

• Benefits
  – Enhances clinical education through exposure to multiple patients by all team members
  – Ability to teach, model, observe, and evaluate clinical skills more effectively than “sitting” rounds
  – Patients and families also learn when we discuss our thought processes or explain things to the team

• Challenges
  – Not all teaching topics amenable to discussion in presence of patient/family
  – Perceptions about rounding inefficiency if not done correctly
Teaching on Rounds

At the Bedside
• Physical examination
• Clinical reasoning
• Provider-patient communication
• Professionalism
• Discussions of treatment and rationales
• Systems-based practice issues

Not at the Bedside
• Psychosocial issues
• Pathophysiology
• Sensitive or broad differential diagnosis discussions
• Issues unrelated to patient care
Video Debriefs*

*Videos were created for certain purposes and we are using these videos out of context. Our review is looking at the videos in the context of Patient and Family Centered I-PASS. They are excellent videos for the purposes of which they were developed.

Using the techniques to improve

Lauren Destino, MD
Round 1

https://www.youtube.com/watch?v=Xsnwd0BmeeY
Round 2

https://www.youtube.com/watch?v=RJQPA2zFobE
Round 3

https://www.youtube.com/watch?v=XZQ7Yy3gxZU
Round 3

https://www.youtube.com/watch?v=SnMoZv1plis
Round 4

https://www.youtube.com/watch?v=8LZJz7GtJA0
Round 4

https://www.youtube.com/watch?v=8LZJz7GtJA0
What Can You Do at Your Institution?

Implementation Considerations

Shilpa J. Patel, MD
Implementation Steps

Understanding the Patient & Family Centered I-PASS Bundle
- All levels must understand and agree upon objectives and goals so can support
- Develop team
- Ensure high-level leadership support and engagement

Assess current environment, map current & develop ideal processes
- Actual diagramming of rounds
- Baseline attitude assessment
- Readiness for change assessment

Adapt bundle to local environment
- Determine scope of implementation
- Develop communication plan
- Iterative cycles w/ FLP input

Data collection
- Baseline data: adapt bundle to prioritized goals
- Iterative cycles with FLP input
- Post-implementation data after training must be sustained

Training of Front Line Providers
- Adapt training according to feedback
- Iterative cycles with FLPs input
- Culture change takes time and ongoing observations with feedback
Institutional Support

• Sponsorship and support from the institution are critical!
  – Chief medical, nursing, safety and/or quality officers
  – Training program directors
  – Division and department chairs

• Champions for PFCR implementation or improvements
  – Well respected physicians and nurses who are opinion leaders
Needs Assessment and Process Mapping

• Needs assessment for insight into current FCR practices

• Ideally a collaborative effort including:
  – Front-line physicians
  – Front-line nurses
  – Intervention champions
  – Family advisory council members
  – Other key stakeholders

• Consider creating a process map
Realistic Planning

You can ADAPT

• Focus on a few elements at once
  – Engaging Family
  – RN at bedside
  – Teach-back
  – Plain Language

• Initial focus should be in response to
  – Needs assessment
  – Process Map
  – Initial Support: Champions and Institution
Realistic Planning
But No Matter What → DO THIS

• Keep the I-PASS rounds structure intact
• Retain training on general principles of high functioning teams and standardized communication
• Engage champions
• Reinforce key elements through direct observation
• Refine implementation using PDSA cycles
Planning for Implementation

- Timeline for implementation is **critical**
- Consider also communication plan
Data Drives Improvement Efforts

• Data collection, analysis, and feedback to team members

• Performance measures should
  – Map back to aims of implementation
  – Address areas of critical vulnerability and challenges
  – Track performance longitudinally
  – Actually be collected!

"After closer investigation, it's become clear that we need to enter more than one value."
Sample Run Chart

Parent/family expressed concerns for the day at the start of rounds

Frequency

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Wash-in period

Month

Post data collection Beyond study

Aggregate n = 10 20 18 28 11 40 33 50 73 59 28 15

Aggregate

1 2 3 4 5 6 7 8 9 10 11 12 13 14

I-PASS

Patient and Family
QI Observations: Where the Real Learning Occurs

Choose your observer:
- Faculty
- Nurse/Nurse Educators
- Quality and Safety Department Members
- Patient Experience Department members
- Family Advisory Council Members/Parents

Choose your tool:
- Activation of Family
- Structured communication
- Health Literacy
- Teaching
QI Observation Tool

Please indicate whether the following individuals were present on rounds at any point during your observation (check all that apply):

- Sr. Resident (≥PGY 3)
- Jr. Resident (PGY 2)
- Intern (PGY1)
- Patient
- Family member
- Attending Physician
- Fellow
- Nurse Practitioner
- Physician Assistant
- Medical Student
- Child Life
- Charge nurse
- Bedside Nurse
- Nursing Student
- Case manager
- Social worker
- Dietician
- Consulting sub-specialist
- Pharmacist
- Other: _______________

Limited English Proficiency present? Y/N/Unclear (explain______)  Interpreter used? Y/N

Core Items

<table>
<thead>
<tr>
<th>Element/Behavior</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parent/family expressed concerns for the day at the start of rounds</td>
<td></td>
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<tr>
<td>2. Nurse present for majority of discussion</td>
<td></td>
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<tr>
<td>3. Rounds Report / written family communication tool completed or updated</td>
<td></td>
<td></td>
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<tr>
<td>4. Teaching occurred on rounds</td>
<td></td>
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</tbody>
</table>
Practice Observation

*Individual → Small Group → Large Group*

- Audience volunteer!
- Watch an example of Patient and Family Centered Rounds
- Use the QI tool to grade us
Plan for Implementation

Small Group Exercise

• What will be your barriers or other barriers?
• How can you start small?
• Could you start large?
• Balancing measures to consider?
Final Take Home Points

• Importance of bringing patients, families, and team members on rounds as partners in the development of interventions

• Critical nature of engaging all members of the inter-professional team

• Emphasizing health literacy principles in communications to create a shared mental model

• Strategic in overcoming challenges to implementation
Questions?
Quote from Family Advisor

• “It has been an honor and a joy to participate as a family advisor in the I-PASS project. Dealing with a serious illness and regular hospitalizations often robs us of our energy and opportunity to be givers beyond the patient we are loving and caring for.”

• “The opportunity to take our experiences and share our strengths and struggles for the benefit of all has been such a gift ... I feel I have received more than I have given.”
Comments from FAC Members at End-of-Project Study Group Meeting

• Liz: I am so thankful to have been involved with the group. Thanks to Dale and Helen for their leadership.
• Sharon: Thanks to all of the FAC members. I enjoyed working with both the large group and the local group. I felt that our viewpoints were always valued.
• Helen: The I-PASS study has been a joy to work with. The degree to which you have been receptive to the voices of the family advisors is almost unique in my experience. I think that I-PASS should be considered a national model for collaboration.
• Dale: Being co-chair for the I-PASS FAC has been a unique experience for me, as well. I had the opportunity to see what real team work looks like and feels like. The FAC members were taken seriously and their comments and concerns were valued and acted upon. We inspired the team to think differently about what really matters to the family. They cared.
• Peggy: We felt really listened to. It has been powerful.