When Patients Speak—Collaboration in Patient Safety

The patient is one of the most important allies in reducing medical errors.1 Research indicates that when patients actively participate in their overall healthcare management, medical errors are reduced.2,3 The Institute of Medicine (IOM) reports have supported this concept, as well. To Err is Human: Building a Safer Health System not only reported that as many as 98,000 deaths occur annually due to medical errors, but also indicated that poor physician-patient communication was one of the root causes.4 The next IOM report, Crossing the Quality Chasm: A New Health System in the 21st Century,5 encouraged patients to exercise control of healthcare decisions by using a shared decision-making process with their physicians, with the goal of improving the quality of care.2 In its most recent report, Patient Safety: Achieving a New Standard of Care, the IOM suggested that “patient safety programs...invite the participation of patients and their families and be responsive to their inquiries.”6

Though improving patient safety in healthcare historically has not included the patient’s perspective, patients have a key role in promoting their own safety.7 Some of the ways in which patients can help their clinicians in this respect include: identifying side effects or adverse events quickly so that appropriate action can be taken; ensuring that treatment is given, monitored, and complied with appropriately; choosing an experienced, safe practitioner; deciding upon a strategy for management or treatment of health problems; and helping to achieve an accurate diagnosis or analysis of a health-related issue.7

PA-PSRS Reports
Reports submitted to PA-PSRS indicate that patients and family members who speak up about patient care issues have not only identified medical errors but have also prevented errors and injuries. Following are just a few examples of the hundreds of such reports submitted to PA-PSRS over the past six months:

- A nurse was providing education to a patient and spouse prior to flushing a PICC line. When the nurse mentioned Heparin, the spouse spoke up and said that the patient was allergic to Heparin. The nurse reviewed the chart and found no Heparin allergy documented. The allergy had not been transcribed onto the chart. New orders were obtained for flushing this patient’s PICC line using saline only.
- An OR schedule indicated that the patient was to have a tonsillectomy and adenoidecetomy. The parent stated, however, that the child was to have a tube removal, excision of polyp, and application of a tympanic membrane patch. An investigation revealed that the initial reservation from the surgeon’s office was incorrect. Clarifications were made, and the correct procedure was performed.
- A patient’s husband approached nursing staff asking if “that band is still supposed to be tied so tight around her arm.” When the patient’s IV had been started two hours earlier, the nurse had forgotten to remove the tourniquet.
- The patient’s son picked up his father who was discharged from the hospital. While en route home, he noticed that his father still had IV access in place. The son telephoned the hospital, and arrangements were made for removal of the IV access.
- A technician was paged for a stat chest X-ray on a patient in a certain bed number. The order was not yet in the computer system. The parent questioned the test. The tech confirmed with the secretary that the test was for that bed. The parent continued to resist the test, at which time the physician was contacted. The X-ray was indeed intended for another patient in a bed that was mislabeled with the incorrect bed number.

Opportunities for Improvement
In most instances, PA-PSRS reports indicate that when patients speak up, clinicians listen and take appropriate action. However, sometimes an error still
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occurs despite the opportunity for recovery provided by a patient’s attentiveness and communication. In order to reveal communication barriers, examples of such occurrences are presented below. Opportunities for improvement present themselves through these cases.

Explaining Medical Terminology
Medical errors may occur when a patient or family member doesn’t understand medical terminology.

- A patient with a dye allergy was ordered a CT scan with contrast. “No allergies” was noted on the admission orders. The allergy was noted on the MAR, but not on the Patient Care Kardex. The nurse asked the patient if he had an allergy to “contrast,” but the patient said “no” because he did not realize that the term meant IV dye. The patient was started on the contrast infusion and only later reported the allergy.

- A physician called the spouse of an elderly patient to obtain consent for a PEG tube insertion, and the spouse agreed. The next day, the daughter visited and complained that a PEG/feeding tube was against the family’s wishes. Upon investigation, the spouse did not understand that what he agreed to was a feeding tube procedure.

These occurrences may have been prevented if lay terms had been used instead of professional terminology.

Not Listening
There are some PA-PSRS reports that indicate that the patient’s concern may have been minimized or dismissed.

- A laboratory technician came to the incorrect patient’s room to draw blood for cardiac enzymes. The patient asked why she was having the blood drawn when her diagnosis was kidney stones and she had already had blood drawn that morning. The tech said to the patient that she didn’t know why and drew the blood anyway, even though a patient ID band and name tag above the bed were present.

- A patient told a lab tech not to draw blood from the right arm, but blood was drawn from that arm anyway. There was an order not to use that arm because it was to be used for a dialysis shunt. The patient also was wearing a color-coded bracelet indicating that the arm should not be used for blood draws.

Sometimes, such errors occur because the healthcare worker is busy caring for many patients. The focus may be upon accomplishing a multitude of tasks, and sensory overload may occur. As a result, the patient’s words may not be heard. Another potential contributing factor may be the traditional model of healthcare interaction that has historically been instilled in healthcare workers. This is a dominance-subordination (parent-child) model in which clinicians are considered the experts and the primary decision makers regarding the patient’s care. In this model, patients are expected to be passive and compliant, supplying information when asked, and following through with the healthcare professional’s advice.

A clinician imbued with the traditional medical model may simply disregard patients’ comments as being uninformed and without merit. This dominance-subordination medical model subverts patient care by discouraging collaboration. Communication is inhibited, and the potential for patient involvement in patient safety is prevented.

Over the past 30 years, however, the asymmetrical power distribution between clinicians and patients has become more balanced. The relationship is becoming similar to an adult-adult relationship, rather than that of parent-to-child. The new patient role is one of empowerment. The distribution of power between the patient and clinician is such that patients are in greater control of their health and encounters with clinicians. The clinician respects the patient and is a resource in assisting the patient in making informed decisions.

The patient empowerment model has been used to address diverse health issues such as: ethical decision making, diabetes management, total hip and knee replacement recovery, improving staff handwashing in hospitals, management of end-stage renal disease, and prevention of medical errors. Collaboration with patients and their families provides for more safeguards to be built into healthcare systems and processes. With several different perspectives that patients, families, and clinicians can provide, safety improvement opportunities can be identified more quickly and effectively.

Patients have a key role to play in promoting their own safety in the healthcare system.
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Respect, But Verify
Many reports submitted to PA-PSRS indicate that, instead of ignoring the patient, the patient’s word is too hastily accepted as accurate. This can result in an error when the patient’s information is not independently verified prior to an intervention.

- A patient was scheduled for a right shoulder ORIF. The anesthesiologist asked the patient if she was having surgery on her left shoulder, to which the patient replied, “Yes.” The anesthesiologist performed an intrascalene block on the left shoulder. After the block was administered, the nurse informed the anesthesiologist that the surgical consent was for a right shoulder ORIF. Having a time out protocol that requires all surgical team members and the patient to be present for site verification may have prevented this occurrence. Also, avoiding the use of a leading question may have avoided this event, i.e., asking which site was to undergo surgery, rather than designating a specific site in the verification question.

- A patient was scheduled for a CT scan of the abdomen. She denied pregnancy in the ED, and the CT scan was performed. Thereafter, a physician notified the Imaging Department that at the time of the CT scan, the patient was 12 weeks pregnant. An HCG test prior to imaging may have prevented this occurrence.

No/Delayed/Inappropriate Patient Communication
Several reports submitted to PA-PSRS reflect patients not communicating or delays in communicating with clinicians. For example, a patient being interviewed for the presence of metallic objects in preparation for an MRI forgot she had an implanted insulin pump. After the MRI, the pump alarm was sounding, and the pump indicated “motor error.” Sliding scale insulin coverage was implemented, and a replacement pump was ordered.

At times, patients/families speak out in inappropriate ways. A patient’s husband was anxious and impatient, stating he wanted a “real” doctor to assess his wife’s pain. There were four nurses present at the patient’s bedside. The husband called out to the unit clerk to call a code. The code was called unnecessarily. While the communication may have been inappropriately conveyed, patients and families are speaking out about an unmet need. The challenge for clinicians is to identify that need and address it effectively and constructively.

Healthcare Professional Communication Skills
Studies of physician communication indicated that physicians redirect and interrupt a patient’s initial descriptions of their concerns after an average of only 18 to 23.1 seconds. This discourages patients from providing complete histories, and can result in missed opportunities to gather important information. The order in which patients discuss their problems does not necessarily relate to their clinical importance. Assuming that the chief complaint is the first complaint mentioned by the patient may be inaccurate.

The key to creating effective provider-patient relationships is communication. Improving communication skills of healthcare providers to encourage patient information sharing improves the accuracy and quality of the information received, thus reducing the potential for medical error, missed diagnoses, and forgotten patient history information. In addition, clinicians who learn communication and information-sharing skills are better prepared to interact with empowered patients.

Increasingly, improving communication skills have become a component of medical school curricula. Common concepts in communication skills programs for clinicians include opening discussions by inviting/welcoming the patient’s participation. No question is considered too stupid/unreasonable, and no information is too trivial to share.

Active listening is used to gather information, balancing the use of both open and closed questions. Discussion is encouraged without interruption or premature closure. Nonverbal indications, as well as how the information is spoken, are identified that might suggest what the patient is experiencing—emotions, conflicts, concerns. This allows a fuller understanding of the patient’s perspective. Other skills include reflecting back to the patient by summarizing information that the patient has shared and requesting/accepting corrections and clarifications from the patient. One concept is “Don’t just do something, stand there!”—pausing several seconds may allow the patient to feel understood and that the information imparted is being respected and taken seriously. Finally, clinicians can check with the patient repeatedly for any additional concerns. The University of Colorado School of Medicine incorporates these techniques into the concepts of “Invite, Listen, Summarize.”
Table 1 presents phrases clinicians can use to encourage open patient communication. Written instruction on such skills is helpful. But opportunities to practice these skills and to receive feedback on these new behaviors are vital to ensure that these skills are internalized and used effectively.11

Patient Communication Skills
Just as clinicians benefit from programs to improve their communication skills, patients can also learn skills to effectively interact with clinicians. Patients can unlearn the old ways of interacting according to the traditional model. Communication skills education helps patients develop respect for their own abilities and opinions.12 Educating patients to become knowledgeable about their healthcare needs and to assume active roles when interacting with healthcare professionals promotes more effective and efficient care and may help to prevent medical errors.2

Patients who feel powerless under the traditional medical model do not automatically become empowered, and need a process to find their own voice.12

Most patient education programs promote disease-oriented information or develop self-care skills, such as self-administration of medications or disease prevention concepts.11 There are fewer patient education programs devoted to the development and improvement of communication skills.11

Communication skills that can help patients to be effective partners in their own care include: clearly describing medical problems or experiences with illness; clarifying expectations; asking for information, as well as clarification; exploring alternatives with the clinicians; providing information; stating preferences; working with an advocate, if necessary; providing feedback; active listening; being constructively assertive; negotiating differences; being mindful of interruptions and topic changes and re-focusing conversations with clinicians on mutual concerns.11

Notes

Table 1. Phrases that May Encourage Patient Communication

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<thead>
<tr>
<th>Questions</th>
<th>Clarifications</th>
<th>Responses</th>
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<tbody>
<tr>
<td>Can you tell me a little more about that?</td>
<td>Let me see if I have this right.</td>
<td>That sounds very difficult.</td>
</tr>
<tr>
<td>Is there anything else?</td>
<td>I want to make sure I understand what you're telling me. I'm hearing that...</td>
<td>Sounds like...</td>
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<tr>
<td>What has this been like for you?</td>
<td>When I'm done, please correct me if I don't have this right. OK?</td>
<td>I can imagine that this might feel...</td>
</tr>
<tr>
<td>Are you OK with that?</td>
<td>When I'm done, please correct me if I don't have this right. OK?</td>
<td>Anyone in your situation would feel that way...</td>
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<tr>
<td></td>
<td></td>
<td>I can see that you are...</td>
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<tr>
<td></td>
<td></td>
<td>I bet you're feeling pretty good about that.</td>
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The Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error (“Mcare”) Act. Consistent with Act 13, ECRI, as contractor for the PA-PSRS program, is issuing this newsletter to advise medical facilities of immediate changes that can be instituted to reduce serious events and incidents. For more information about the PA-PSRS program or the Patient Safety Authority, see the Authority’s website at www.psa.state.pa.us.

ECRI is an independent, nonprofit health services research agency dedicated to improving the safety, efficacy and cost-effectiveness of healthcare. ECRI’s focus is healthcare technology, healthcare risk and quality management and healthcare environmental management. ECRI provides information services and technical assistance to more than 5,000 hospitals, healthcare organizations, ministries of health, government and planning agencies, and other organizations worldwide.

The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization dedicated solely to medication error prevention and safe medication use. ISMP provides recommendations for the safe use of medications to the healthcare community including healthcare professionals, government agencies, accrediting organizations, and consumers. ISMP’s efforts are built on a non-punitive approach and systems-based solutions.