The George Washington University Hospital & Graduate Medical Education

Quality & Patient Safety
THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Communication

- ED Resident to Admitting Resident
- Admitting Resident to Attending
- Admitting Team to ICU
- Admitting Team to Primary/Charge Nurse
- Nursing to Sitter/Patient Care Technician
- Resident to Radiology
- Admitting Team to Social Work/Case Mgmt
- Admitting Team to Anesthesia/OR
- Admitting Intern to Night Float
- Floor/ICU RN to OR Nurse
- Primary RN to PT/OT
- Night Float Intern to Resident
- OR RN to PACU/ICU RN
- ED RN to Admitting RN
- PACU/ICU RN to floor RN
- Admitting team to Consult Team
- Shift-to-Shift Nursing Handoff
- ED Resident to Admitting Intern
- Admitting Resident to House Operations Supervisor
- Consult Team to Admitting Team
Lee et al. noted that in 14% of consultations, the requesting physician and the consultant did not agree on the reason for consultation.

They found that when there is no agreement on the reason for consultation, then “they were very unlikely to agree on its value.”
Improved Communication Improves Teamwork

Positive Outcomes of Effective Teamwork on Health Care

- Reduced length of stay
- Higher quality of care
- Better patient outcomes
- Greater ability to meet family member needs
- Improved patient experience
- Lower nurse turnover
Communication Breakdowns Cause Treatment Delays


- Communication: 86%
- Availability of Information: 39%
- Leadership: 19%
- Staffing: 25%
- Organizational Culture: 18%
- Environmental Safety/Security: 19%
- Continuum of Care: 52%
- Patient Assessment: 77%
- Care Planning: 20%
- Competency and Credentialing: 35%
- Procedural Compliance: 17%
Communication Breakdowns Cause Infection-Associated Events

Root causes of infection-associated events (2005)

- A. Communication 75%
- B. Environmental Safety/Security 50%
- C. Continuum of Care 39%
- D. Competency or Credentialing 38%
  - E. Procedural Compliance 38%
  - F. Patient Assessment 25%
  - G. Leadership 25%
  - H. Staffing 13%
- I. Availability of Information 13%
- J. Orientation and Training 12%
- K. Organizational Culture 12%
Communication - Verbal vs. NonVerbal

- Words used: 55%
- Vocal elements: 7%
- Non-verbal communication: 38%

**History of Present Illness:**

77 yo WF with h/o spinal fusion in early 2013 complicated by MRSA wound infection, breast cancer, Whipple procedure, and recent UTI with h/o chronic UTI, presenting with continued dysuria and decreased ability to urinate, no stool x6 days, fatigue, R>L bilat leg swelling, and AMS per family members worsening over the last week. Per pt's granddaughter pt has been more confused and lethargic throughout the week, significant change from baseline. Pt denies fevers at home, however chills are common for her 2/2 to tamoxifen therapy. Of note, per her husband pt had a PET scan this past week that showed no new cancer but area of inflammation/compression at T3, which is where pt's MRSA wound infection originated. Pt additionally c/o "migratory pain" that has been worsening over 2 weeks in back, R shoulder, chest and R ankle, that pt attributes to OA. Pt states she has chronic UTIs, most recently 2/2 catheter infection at Jackson Memorial Hospital. Regarding constipation, pt used enema 10/28/2013. Stools have been very dark recently, taking iron daily.

ED course: Pt received 2x 1L NS bolus. Pt found to have H/H 6.1/18.6 and was ordered 2 units pRBCs. WBC elevated to 18.92, UA grossly positive. CT abdomen and pelvis as well as LE dopplers were ordered. BMP showed Na+ of 116. Pt began vancomycin/zosyn for broad spectrum coverage. DRE performed, hemoccult negative.

**Interval History:**

10/29/13: **Ortho Consult**
- **ID Consult**
- Acute Pain Service Consult
- Rheumatology Consult w/ right knee tap consistent with septic joint, blood cx positive for GPC

10/31/13: **Ortho – Washout of right knee – Aspiration of right ankle and right shoulder**

11/2/13: **Repeat aspiration of L knee; I+D of L hip, component exchange of L hip hemiarthroplasty, placement of antibiotic beads**

11/5/13: **Transferred from ICU to floor, no transfer note done by ICU team.**
PT#

HPI / Reason For Admission:
Migratory pain, AMS

Hospital Course To Date:
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PCP: Dr. N
Ortho: Dr. N
Oncology:
Husband: N
Physician – Patient Communication
2013 GWUH HCAHPS Percentile Ranking
Effective MD-Patient Communication: Why Is It Important?

- Clinical outcomes
- Patient safety
- Community reputation
- Patient satisfaction
- Decreased risk for litigation
- *It’s the Right Thing to Do*
Patient Experience

The sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care:

• Clinical care
• Patient-physician interactions
• Communication about diagnosis, treatment, medications
• Treatment environment
Patient Experience: Emerging as a Primary Driver

• More than **80%** say reputation for skill and quality of care is the most important criterion when selecting a hospital or physician

• **60%** indicate that high levels of patient satisfaction is one of the top three priorities influencing their selection
The Patient Experience: Patient-Physician Relationship

Leading predictors of highest overall patient satisfaction:

- Effective Communication
- Compassion and Empathy
- Patient Engagement
The Patient Experience: The Cost of Failed Communication

The relationship between patient and physician and their communication have a significant impact on outcomes, safety, and quality:

- 70% of medical malpractices cases are due to relationship and communication issues between clinician and patient.
- 66% of sentinel events are due to error in communication.
Improving the Patient Experience: Effective Communication

- Claims of malpractice, liability
- Decisional conflict
- Readmissions
- Calls for information, clarification

- Clinical outcomes
- Greater compliance
- Good Handoffs
- Patient Satisfaction
• Agency for Healthcare Research and Quality, Department of Defense. TeamSTEPPS. [www.ahrq.gov/teamsteppstools/instructor/index.html]
• *Barfod TS, Hecht FM, Rubow C, Gerstoft J.* BMC Health Serv Res. 2006 Dec 4; 6:154. Epub 2006 Dec 4
• *J Am Osteopath Assoc January 1, 2005 vol. 105 no. 1 13-18*
• JD Power and Associates National Hospital Service Performance Study 2008
• Shortell SM, Marstellar JA, Lin M et al. The role of perceived team effectiveness in improving chronic illness care. *Med Care* 2004 Nov; 42:1040–1048