

Pandemic.



Not our favorite word.
But possibly here. Now.

As I write this, COVID-19 has been documented by the World Health Organization (WHO) in several US States and over fifty countries on most continents.

Panic.

Across the United States and in other parts of the world persons are stocking up on basic supplies, causing shortages at local stores not unlike storm preparation. In a way, this is a storm as we look at the potential of our personal health and healthcare system be overwhelmed. However, unlike a storm, the stores and commerce in general will most likely stay open and functioning. Some adaptations will need to happen to limit exposure. Persons are often unaware they are ill, apparently,

and therefore can shed or share the virus long before they have symptoms.

Perspective.

This is not just another flu. We really don't know yet what the actual impact of the COVID-19 will be. Mortality reports suggest it will cause more deaths than the flu. However, for most persons, the virus will be like an annoying cold. And, even at the rates being noted in the news, COVID-19 causes fewer deaths daily than medical error causes.

Patients.

The World Health Organization offers the following:

RECOMMENDATIONS AND ADVICE FOR THE PUBLIC

If you are not in an area where COVID-19 is spreading or have not travelled from an area where COVID-19 is spreading or have not been in contact with an infected patient, your risk of infection is low. It is understandable that you may feel anxious about the outbreak. It's a good idea to get the facts from reliable sources to help you accurately determine your risks so that you can take reasonable precautions. Seek guidance from WHO, your healthcare provider, your national public health authority or your employer for accurate information on COVID-19 and whether COVID-19 is circulating where you live. It is important to be informed of the situation and take appropriate measures to protect yourself and your family.

If you are in an area where there are cases of COVID-19 you need to take the risk of infection seriously. Follow the advice of WHO and guidance issued by national and local health authorities. For most people, COVID-19 infection will cause mild illness however, it can make some people very ill and, in some people, it can be fatal. Older people, and those with pre-existing medical conditions (such as cardiovascular disease, chronic respiratory disease or diabetes) are at risk for severe disease.

Peace.

-Lisa Morrise

Consumers Advancing Patient Safety

March 2020



Patients Participating:

Several Patients presented their thoughts at CMS Quality Conference 2020, including **Travis Rieder** sharing his powerful story about opioid withdrawal and his advocacy for better counseling for tapering patients from opioid medicine. Rieder is a bioethicist at John Hopkins University. He also has a very real experience with utilizing opioid pain medication after an accident and how he was suddenly expected to stop using a dose that was most likely too high. His TEDx talk can be found [Here](#).



Precious McGowan also presented at the CMS Quality Conference. Precious advocates in the End Stage Renal Disease Network (ESRD). Precious presented at a Plenary and also break-out sessions. Find out more about McGowan and her advocacy [here](#).

Patients Representing:



Deputy Surgeon General of the United States, Rear Admiral (RADM) Erica G. Schwartz swore Patient Advocate **Armando Nahum** and 3 others into The Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB) in D.C. Previously, Patient Advocate **Alicia Cole** was the first patient to serve on the PACCARB.



How to Manage Your Medicines With Brian Isetts, PhD, BCPS, FAPhA

Practical Discussion of issues like:

*How persons may personally take charge of their medicine and organize it for:

- Ease of taking
- Ease of re-ordering
- Understanding the what, why, when and hows of medicines.

*How persons may obtain “extra” medicine to have on hand in the event of a disaster or medicine shortage due to supply interruptions

*How persons may be counseled on these topics.

Medicine Management Webinar

Thu, March 19, 2020 12:00 PM - 1:00 PM (CST)

Please join my meeting from your computer, tablet or smartphone.

<https://global.gotomeeting.com/join/300664373>

You can also dial in using your phone.

United States: [+1 \(872\) 240-3311](tel:+18722403311)

Access Code: 300-664-373



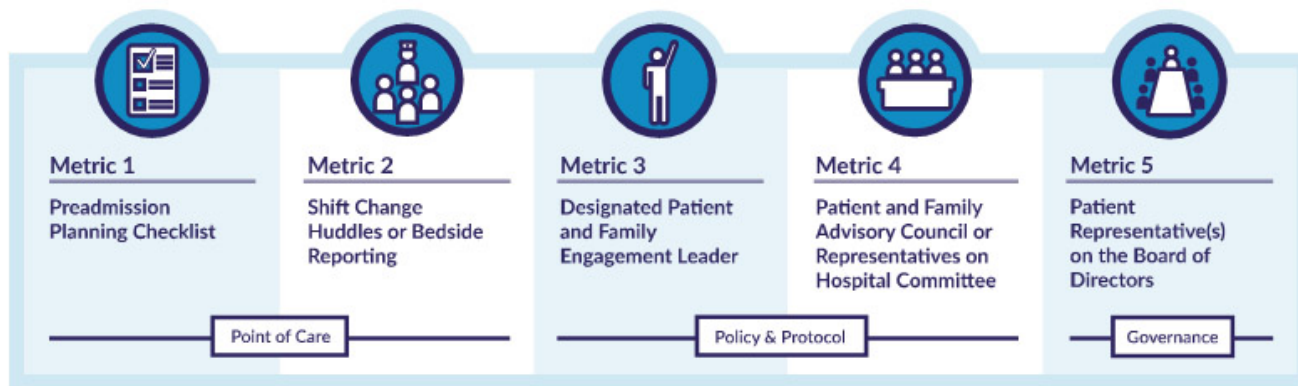
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CAPS AT WORK

CAPS' Consultant Rachel Weissburg, MS, worked from Spring 2019 through last September on developing Guides for each of the CMS HIIN PFE Program Metrics in coordination with the American Institutes of Research (AIR.ORG). Those HIIN PFE Metrics were:

FIVE METRICS FOR PATIENT AND FAMILY ENGAGEMENT



SOURCE: Centers for Medicare and Medicaid Services (2014)

AMERICAN INSTITUTES FOR RESEARCH | AIR.ORG

The Guides for each Metric can be found on the CAPS Website, www.patientsafety.org and are linked below.

PFE Resource Guides

- [Metric-1-508](#)
- [Metric-2-508](#)
- [Metric-3-508](#)
- [Metric-4-508](#)
- [Metric-5-508](#)

We will feature key information from each guide over the next several months. In the first PFE Implementation Guide for Hospitals Metric 1: Preadmission Checklist Planning find the following:

Five Suggested Steps to Implement PFE Metric 2

1. Engage key stakeholders in identifying target areas for improvement
2. Secure buy-in from leadership and staff
3. Determine scope and logistics of implementation
4. Implement new process of shift change huddles or bedside reporting
5. Evaluate and expand shift change huddles or bedside reporting

Be sure to click on the link above for PFE Metric 2 (508 Compliant) to get more in-depth information about how hospitals may implement Preadmission Planning Checklists at the Point of Care. Stay tuned for more information from the PFE Resource Guides, developed for AIR and the CMS HIIN PFE Program.

Hand-washing technique with soap and water



Wet hands with water



Apply enough soap to cover all hand surfaces



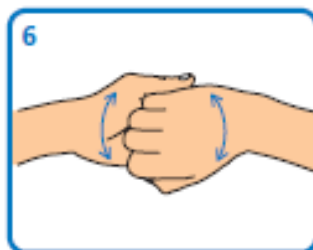
Rub hands palm to palm



Rub back of each hand with palm of other hand with fingers interlaced



Rub palm to palm with fingers interlaced



Rub with back of fingers to opposing palms with fingers interlocked



Rub each thumb clasped in opposite hand using a rotational movement



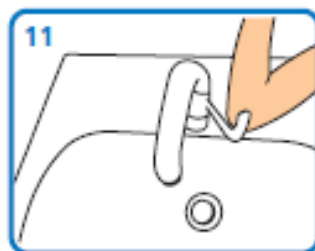
Rub tips of fingers in opposite palm in a circular motion



Rub each wrist with opposite hand



Rinse hands with water



Use elbow to turn off tap



Dry thoroughly with a single-use towel



Hand washing should take 15-30 seconds

Consumer Advocacy Panel (CAPS CAP) Interview – Donna Drouin

Donna Drouin moves patient safety and quality forward in Connecticut. We caught up with her a few weeks ago and asked about her volunteer work. **CAPS:** When did you start your advocacy?



Donna: I was a healthcare quality consultant for several years. Beginning in 2010 a family member died each year for four years each with notable hospital related oddities. My mom was the fourth. She was discharged with a broken ankle right in front of my eyes. Mom was 95 and taken initially to the hospital after a fall and admitted by the ER doctor. Despite multiple requests to find out why she couldn't walk, three days later I rounded the corner to her room to be told she was being discharged to a rehab facility. I don't think they ever even took off her sock to look at her ankle. They only repeated she was a 2 person assist without answering why. I asked the nurse to get the hospitalist (who, in 3 days of my being there 8am to 11pm, I never saw). She did, and the hospitalist stood in the hallway about 15

feet away from my mom, tipped her head to pretend she was looking at mom's bruised ankle that I was holding in my hand UNDER the patient table and announced she didn't see anything and proceeded down the hall! I looked at the nurse and said did I just hear what I thought I heard? She said "yes" and shook her head in disbelief as the gurney whizzed around the corner and she was taken to the rehab facility.

At the rehab facility I asked for an immediate portable x-ray recounting the hospital experience. They said the ankle was broken. They arranged for a wheelchair transfer at 10am (only availability) for a 12:30 appointment in the middle of summer. Fortunately, we could wait in the lobby and not the parking lot.

I was shocked and bothered I didn't stop that gurney and demand she be cared for. After a very blunt conversation with the CMO I filed a complaint with the State and the hospital was sanctioned. It was a short time after that I had the privilege of meeting Cheryl Rodgers who called to see if I would like to be a part of a new Middlesex Hospital PFAC. I jumped at the chance, knowing if I felt like a deer in the headlights in the hospital others probably do as well....and that had to change.

CAPS: How has your advocacy evolved?

Donna: I was voted Chair/co-chair for the first 6-7 years and we engaged a group of 10-12 people all focused on using our experiences to make a better hospital experience. Our members were smart. They were given roles and responsibilities to carry out and deliverables. All the projects came back to the larger group to tweak and or approve. Everyone had a different talent. One woman was excellent at looking at a document and immediately seeing what people may have trouble understanding. We also had an expert in health literacy who was indispensable to the group...we learned tri-folds were hard for people to understand.

My mom's discharge was rushed. I later discovered that there was an 11am discharge time target at the hospital. It illustrated how targets can cause unintended consequences.

We made an incredible impact in our first few years and earned the respect of our hospital partners and staff. We now have patient advocates on 24 hospital committees. We brought our results to the Connecticut Hospital Association and asked them to consider a statewide activity.

CAPS: What projects have you been involved in?

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Donna: On the hospital level a few stand out. One was getting uniforms/colors standardized by discipline so patients and families knew what different staff member jobs were by the color of their uniform. Another was getting white boards into the ER waiting rooms and ER volunteer Ambassadors to keep patients and family comfortable and informed during an ER visit. We have many more also. The PFAC can improve the quality of health care by including patients and families in the processes. We have also worked with Rhode Island and Massachusetts in expanding PFAC work.

CAPS: What would you recommend to persons who want to advocate for quality and safety?

Donna: If you're a Patient Advocate, keep your eyes and ears open. Take a notebook with you when you go into a hospital. Take pictures with your cell phone of both good and bad things. Put notes together and reach out to the hospital's quality staff. You can help improve their understanding of barriers to achieving quality health care. Be aware, ask questions, and don't be afraid to say, "I don't understand."

We developed three guides for patients. One is for preparing to go to the hospital. (See https://middlesexhealth.org/files/dmHTMLFile/hospitalstaychecklist_flyer_4.30.141.pdf) One is for while the patient is in the hospital. One is for when you leave. Volunteers assist in the distribution of the guides to patients and encourage the patients and families to read and use them.

CAPS: What would you recommend health care systems do to improve quality and safety?

Donna: Health care systems absolutely need to include individuals and families. They need advisors to be involved before then end of the process. They need to look at measures that have unintended consequences similar to the discharge example.

Health care systems need to educate patient and family advisors in how a hospital is run. The PFAC should be a cooperative effort where advisors and staff listen to each other. Systems should involve patients in root cause analysis and how they use the "5 why's."

CAPS: What are your future plans?

Donna: Well, first, I'd like to see JCAHO, NCQA, AAAHC and CMS all have measures for PFAC participation and proven results. I'd like to see 24-hour registered nurse presence in all Assisted Care facilities. We need a greater focus on elder care. I would include simple to read and understand medical policies, eliminate superfluous blah blah... I could go on for a week!

Second, we need to educate PFACs in things like root cause analysis and the five why's.

I'm proud to say that the Connecticut Hospital Association has been able to support the development of PFACs in all Connecticut hospitals

CAPS: Thanks Donna!

Archived Event:

On January 16, CAPS presented the Webinar, “**Healing after Harm.**” The webinar may be found under News on the CAPS webpage, patientsafety.org. A definition of “harm” is “Ill treatment; the impairment of physical or mental health (including that suffered from seeing, or hearing another person suffer ill treatment)” When harm happens in healthcare, how patients, providers and administrators respond can mitigate or exacerbate the situation.

Mary Ellen Mannix explains that after the death of her son, she sought legal remedies to the harm that occurred. But that did not lead to healing. She studied Restorative Practice which is a social science that studies how to improve and repair relationships between people and communities. In this Webinar, Mannix explains how Restorative Practice can assist in providing Healing to all parties to Harm, including patients, caregivers and providers. Shame is removed from the process leading to being able to answer how all parties will move forward.

Mannix sees Communication and Optional Resolution (CANDOR) as a Restorative Practice. Martin Hatlie explained how CANDOR evolved from the AHRQ Seven Pillars Tool Kit and developed three basic tenets:

- Compensate quickly and fairly when inappropriate medical care causes injury
- Support clinicians vigorously when care involved was reasonable
- Reduce patient injuries (and claims) by learning from our patients’ experiences

Hatlie shared lessons learned from implementation of CANDOR at over 200 hospitals. He noted that thirty-five states have facilities that have adopted CANDOR practice.

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And, please like our Facebook Page: <https://www.facebook.com/patientsafety.org/?ref=bookmarks>

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