focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Using Social Media to Improve Patient Safety

BY SUSAN CARR, EDITOR AND ASSOCIATE PUBLISHER, *PATIENT SAFETY & QUALITY HEALTHCARE*

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Facebook. Twitter. Wikipedia. The names alone may cause eyes to roll and prompt a quick run for the exits. Despite widespread skepticism, these and other interactive sources of information and communication, referred to as *social media*, continue to proliferate.

Early adopters in the patient safety community are using social media across all disciplines, demographics, and work environments. They are finding that the benefits—direct, rapid communication and enhanced networking—outweigh the difficulties, such as managing one more thing in already-busy schedules.

As with all other resources, it is important to evaluate the integrity of information and the motives of those with whom you communicate. Overall, as debate about reliability, efficiency, and privacy continues, the use of social media in health care seems certain to expand.

What are social media?

Social media include online tools and services that allow users to generate and share content directly, without traditional intermediaries such as publishers and broadcast organizations. Blogs, wikis, Listservs, social networks, and video-, photo-, and slide-sharing sites allow users to post material to the Internet without expense or technical expertise.

The original developers and users of social media were individuals—college students staying in touch with friends or writers blogging to reach audiences directly. Now, organizations, businesses, governments, and traditional media outlets are using social media for broad, public communication.

One way to make sense of this fertile online world is to view it in terms of levels of participation. Many of us first experience social media as members of the audience, participating as interested readers, soaking up content but not actively participating. Most social media applications can be viewed with little or no commitment.

Blogs and YouTube are publicly available. Twitter requires only a user name and password. Facebook and LinkedIn require each user to establish a profile with basic identifying information. Individuals may become more involved by commenting on blogs, participating in Listservs, posting videos, publishing their own blogs, or creating a Facebook group. The programs are user-friendly and adaptable, allowing users to participate with ease.

> "Because organizations are now using the Internet to distribute news, social media can be used to stay current, even if the content itself appears in a print publication."

Social media: A resource for patient safety

Social media have become the most effective way to monitor recent developments in patient safety. The developments themselves—news, research, educational resources, regulatory announcements—usually appear first in traditional media, and are more numerous and widely dispersed than most people can hope to keep track of on their own.

Because organizations are using the Internet to distribute news, social media can be used to stay informed, even if the content itself appears in a print publication. With mobile technologies, such as smartphones, staying current can mean receiving news virtually anywhere in real time.

Users of social media can choose what they consider trusted sources of information and the style of notification they find most useful. Many membership organizations are using Twitter and RSS (really simple syndication) feeds to

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For further reading

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Follow NPSF on Facebook and Twitter
NPSF is now on Facebook and Twitter. To get the latest patient safety news and updates on Foundation activities, follow us on Facebook at *http://www.facebook.com/pages/National-Patient-Safety-Foundation/197731443331?ref=mf* and on Twitter at *http://twitter.com/theNPSF*

announce educational programs and using Facebook to build communities of people with shared interests. According to medical web site manager Ed Bennett, as of late November 2009, 473 hospitals in the US were using social networking tools, comprising 218 YouTube channels, 254 Facebook pages, 356 Twitter accounts, and 57 blogs.[1]

> "By enabling participation across traditional boundaries, social media can be a positive disruptive force, equalizing influence and access and mitigating the distancing effect of authority."

Because Twitter is immediate, public, and searchable, it is an especially effective way to monitor current news. Although short (140 characters maximum), the messages, or "tweets," may include links to information in newspapers, blogs, and web sites, as well as direct reports and comments.

A person can employ an ongoing Twitter search that automatically displays any message including the words "patient safety." The messages come from individuals and organizations all over the world, are easy to scan, and often provide information and connections that some users may have no other way to access.

How can social media improve patient safety?

Beyond traditional activities such as membership development, education, and resource distribution, some individuals and organizations are taking advantage of opportunities offered by social media to leverage new opportunities to participate directly in the patient safety discussion.

In February 1998, NPSF became an early adopter of social media by starting a Listserv, Patientsafety-l.[2] This Listserv continues to offer open discussion with a clear focus on patient safety. Individuals who read and contribute to discussions on the NPSF Listserv represent the wide range of expertise and experience of people interested in patient safety.

NPSF monitors the Listserv to keep discussion focused on patient safety, but this online forum is open to all. As with all social media, the value of the Listserv is based on its members' contributions. While "lurkers"—those who read but do not contribute—can learn a great deal, the greatest benefit comes from contributing information, questions, and comments.

Patient safety is improved when individuals apply themselves directly to making a difference in any setting, which includes active participation in discussion and group learning of the sort that is available through the Listserv and other social networking programs.

To develop a culture of safety, patient safety leaders often encourage stakeholders to disrupt the status quo to one degree or another.

- Institutions are being challenged to break down hierarchies and professional silos to enable clinicians to collaborate more effectively.
- Patients are being encouraged to participate actively in their own care and to remind clinicians to wash their hands.
- Families are being asked to be vigilant, to ask questions, and even to call for rapid response teams when necessary.

By enabling participation across traditional boundaries, social media can be a positive disruptive force, equalizing influence and access and mitigating the distancing effect of authority. This movement has just begun, but some individuals and organizations are using social media to talk about their work and experiences in a disarmingly direct and transparent way that changes the status quo. In addition to the NPSF Listserv, this kind of communication can be found on a number of blogs.

One example is Paul Levy's blog, Running a Hospital.[3] Levy, the CEO of Beth Israel Deaconess Medical Center in Boston, often uses his blog to discuss his organization's safety initiatives and commitment to transparency. Levy's posts frequently draw responses from readers including clinicians, employees, and patients, who engage him in spirited public discussion. Levy ensures that discussion is relevant and respectful by approving, or "moderating," the comments.

What does the future hold?

At the 10-year anniversary of the Institute of Medicine report, *To Err Is Human*, experts noted that many healthcare professionals are unfamiliar with concepts of patient safety, and improvement has been slow.[4-5] Social media already show potential to exert a positive disruptive force,

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NPSF Winter News and Highlights

Lucian Leape Institute releases papers on "transforming healthcare" and medical education reform

The Lucian Leape Institute at NPSF has issued a paper outlining measures necessary in reforming and improving the safety of the healthcare system. The paper appears as the Editor's Choice in the December 2009 issue of *Quality and Safety in Health Care*, a *British Medical Journal* publication. To the read the article, visit: *http://dx.doi.org/10.1136/qshc.2009.036954*

In January, the Institute will also release its first white paper which points out the need for an increased emphasis on patient safety in medical education and makes reform recommendations. For more information, visit *www.npsf.org*

New initiative announced: Improving Safety at America's Public Hospitals

Kaiser Permanente, along with NPSF and the National Association of Public Hospitals and Health Systems, has announced the launch of the Patient Safety Initiative at America's Public Hospitals. This 2-year program is designed to enhance patient safety programs at public hospitals, thereby ensuring safe, high-quality care for vulnerable and low-income populations who depend on publicly supported healthcare institutions for medical care.

Kaiser Permanente contributed generous funding to support 85 hospitals' participation in the program. There is potential to expand this program to all 140 NAPH member hospitals. See the article on page 4 for more information about this initiative.

Patient Safety Awareness Week is March 7–13

Join hospitals and healthcare organizations across the country in celebrating Patient Safety Awareness Week, a national campaign focused on improving the safety of the healthcare system through education and awareness-building at the community level. The theme for 2010, Let's Talk! Healthy Conversations for Safer Healthcare, emphasizes the role of open and respectful conversation between patients and providers as a key to effective communication and enhanced patient safety. For details and to find out how your organization can participate, visit *http://www.npsf.org/hp/psaw/*

Nominate individuals and organizations for 4 NPSF awards

NPSF invites you to submit nominations for 4 awards to be presented at the 2010 Annual Patient Safety Congress, May 17-19, in Orlando, Fla. The deadline for nominations is Friday, February 12, 2010 at 5:00 pm EST.

These awards recognize individuals and organizations that have demonstrated outstanding leadership and accomplishment in patient safety. Details and nomination forms are available at *http://www.npsf.org/npsfac/awards-10.php*

Seminar series focuses on healthcare-associated infections

NPSF and Lexington Healthcare announce the 2010 Risk Management and Patient Safety Seminar Series titled

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educating the public, supporting healthcare professionals and institutions in their safety efforts, and aiding healthcare consumers. Social media can aid patients in their quest not only to be better informed, but to be much more effective—and demanding—advocates in their own care and in the governance of institutions. NPSF

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Safety-Net Hospitals: Unique Challenges and a New Program to Address Them

BY JULIE BASTIEN, MBA, RACHEL CROW, AND DAVID COLETTA, NPSF

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Hospitals that disproportionately treat poor and underserved patients have been found to have lower quality of care than those serving a broader and less economically challenged patient base.[1] In 2007, Smith et al found that increased financial pressure on hospitals and reduced profits are associated with an elevated likelihood of preventable medical errors.[2]

What Is a Safety-Net Hospital?

The Institute of Medicine defines safety-net hospitals as those that harbor these core characteristics:

- By legal mandate or explicitly adopted mission, they maintain an "open door," offering patients access to services regardless of their ability to pay; and
- A substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.[3]

Yet efforts to improve the safety of public hospitals—a primary component of the safety net—by applying core elements of safety work have shown results. For example, the New York City Health and Hospitals Corporation's transparency efforts recently earned the John M. Eisenberg award. The award recognized their work to share outcomes data and transform their systems and culture over 10 years to inculcate elements of team-based, high-quality healthcare processes.[4] Applications of the "Toyota method"—often cited as a process to improve safety through efficient management and rapid improvement—have been successful.[5-6]

Patient Safety Initiative aims at helping public hospitals

With a focus on replicating similar successes in a hospital population, NPSF, in partnership with the National Association of Public Hospitals and Health Systems (NAPH) and Kaiser Permanente, has launched a new program for US safety-net hospitals: The Patient Safety Initiative at America's Public Hospitals.

This initiative, launched in October 2009 with generous funding from the Kaiser Permanente Community Benefit Fund, is designed to position public hospitals at the forefront of high-quality healthcare by accelerating patient safety efforts in each organization and the communities they serve. The program will draw on the strength and commitment of NAPH, NPSF, and Kaiser Permanente to create and foster a far-reaching community of safety-net hospitals nationwide. The Patient Safety Initiative has been established to integrate nationally recognized tools and resources, offer ongoing educational opportunities, and initiate open forums for communication, collaboration and dynamic idea exchange.

The initiative has been framed to include 3 phases of enrollment and, with 42 NAPH member hospitals already enrolled in phase 1, the program is poised to achieve its long-term goal of engaging all 140 NAPH member hospitals nationwide. This phased effort will integrate patient safety into the behavioral fabric of each organization and encourage broad collaboration among all stakeholders, including patients and families, executive and clinical staff, and the many communities served by public hospitals across the US.

What are the Patient Safety Initiative's goals?

- Position public hospitals on the leading edge of patient safety and quality care
- Establish a consistent and shared pool of patient safety knowledge, tool sets, and techniques
- Develop a community of public hospital clinicians, patient safety and quality leaders, and hospital executives committed to this initiative
- Deliver on the imperative to transition from patient safety awareness to results-driven programs
- Create patient and community programs fostering communication that engages, informs, and builds continued confidence in care and the public hospital system

Participating organizations will receive an enhanced level of access to NPSF's programs and established expert community.

Initiative benefits help hospitals achieve these goals

The initiative offers the following benefits to help position public hospitals as leaders and change agents in their communities and the industry at large:

1. **Organizational membership in NPSF's Stand Up for Patient Safety program** to engage all staff, as well as patients and families, in improvement efforts. The Stand Up program provides value across member organizations, with a focus on essential patient safety competencies and cross-team implementation strategies.

2. **Access to scholarships for the Patient Safety Leadership Fellowship program**, an intensive program in collaboration with the American Hospital Association that helps shape the safety improvement leaders of tomorrow.

3. **Complimentary registration and subsequent discounts for staff to attend the NPSF Annual Patient Safety Congress**, a multidisciplinary gathering for industry leaders.

"[The Patient Safety Initiative] is designed to position public hospitals at the forefront of high-quality healthcare by accelerating patient safety efforts in each organization and the communities they serve."

4. **Patient health literacy and communication tools,** including the successful Ask Me 3 program from the Partnership for Clear Health Communication (PCHC) at NPSF, targeted community engagement programs and presentations, and detailed training and deployment methodologies.

5. **Specific program measurement tools** to establish key baselines, identify progress and areas for improvement, and gauge levels of success against predefined objectives. Measurement and benchmarking will serve to demonstrate the impact of the Patient Safety Initiative as a whole and showcase success stories from each organization.

6. **A public hospital patient safety community** to be formed using web-based discussion forums, teleconferences, and other communication mediums to provide new opportunities for networking and the sharing of best practices among the group.

As the initiative progresses, it will continually focus on developing safety culture and leadership, enriching a patient safety infrastructure, and expanding a capacity for measurement that yields evidence of improvement in patient safety and quality. This program will also generate attention and visibility at the local and national levels for participating organizations that strive to improve safety on the front lines of care.

Linking these unique, indispensable public hospitals will create a community of organizations and individuals committed to achieving positive outcomes for patients and removing unnecessary inequities in care. **NPSF**

What Hospital Leaders Are Saying About The Patient Safety Initiative

"As a public hospital striving to exceed our community's expectations for quality and patient safety, we eagerly seek out best practices and benchmarking opportunities. To that end, this Patient Safety Initiative would further our quest for excellence by allowing us to share what we have learned and, but more importantly, we would be excited to hear from others about their great work. The community of colleagues could only enhance what we know and take us a step higher."

—Andrea Lavallee, RN, MSN, Patient Safety Officer, Imperial Point Medical Center Fort Lauderdale, Fla

"Participation in this initiative will help to support NYCHHC's efforts in this regard and provide opportunities for ongoing learning and sharing of best practices with/from experts and colleagues. Most importantly, we believe this collaboration with NPSF will enable NYCHHC facilities to 'move to the next level' in patient safety, exceed our current levels of performance, enable sustainment of efforts, and support the achievement of our vision of being recognized as one of the safest healthcare systems in the nation."

—Caroline M Jacobs, MS Ed, MPH, Senior Vice President, Patient Safety, Accreditation and Regulatory Services, New York City Health and Hospitals Corporation

"The structure and rigor with which the initiative is being planned will strengthen the development of leadership in patient safety at Santa Clara Valley Medical Center, not only among our peer group but in the community."

—Carolyn H Brown, RN, MS, Director, Quality and Safety, Santa Clara Valley Medical Center San Jose, Calif

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as I see it

Collaborating to Support Those Involved in Adverse Events

BY LINDA K. KENNEY, PRESIDENT AND EXECUTIVE DIRECTOR, MEDICALLY INDUCED TRAUMA SUPPORT SERVICES

Developing effective methods for supporting care providers involved in patient adverse events poses challenges for many organizations. To gain insight into how healthcare organizations are addressing this need, Medically Induced Trauma Support Services (MITSS), based in Chestnut Hill, Mass, hosted a forum in March 2009 that explored practitioners' experiences in developing programs to support clinicians involved in medical errors or adverse events.

The following text is reprinted by permission of MITSS from a report based on the dialogue that took place at this forum. The full report, "Disclosure and Apology: What's Missing? Advancing Programs that Support Clinicians," is available on the MITSS web site at http://www.mitss.org/MITSS_WhatsMissing.pdf.[1]

In November 1999 (the same month the Institute of Medicine released its famous report, *To Err Is Human*), I was scheduled for total ankle replacement surgery at a major medical facility in Boston. Instead of waking up with a new ankle, I awoke several days later to find that the nerve block had been delivered accidentally to my heart, causing me to go into cardiac arrest.

I had been rushed into a nearby operating room that had been prepared for another patient's cardiac surgery. There, I received an emergency sternotomy with cardiopulmonary bypass for cardiac resuscitation. Eventually I made a full recovery.

That incident had a profound effect on my family, my friends, and me. I also was exposed to a side of health care most patients and families do not see: I witnessed the emotional impact the adverse event had on my orthopedic surgeon, the anesthesiologist, code team, and other healthcare providers. It wasn't just business as usual for them; they suffered, too, and found themselves as unsupported as my family and I were. I knew something needed to be done.

MITSS supports healing for clinicians, patients and families

I founded MITSS (Medically Induced Trauma Support Services) in June 2002. Our mission is to support healing and restore hope to patients, families, and clinicians following adverse medical events. MITSS recognizes that everyone involved in an adverse event needs support. We have spent time raising awareness and educating healthcare consumers, professionals, and organizations about the emotional impact of adverse events and the need for support services.

Our organization has been providing direct support to patients and families as well as individual clinicians from the beginning. MITSS also has advocated that healthcare institutions build their own support infrastructures for their staff. We have served as consultants and advisors in building some of those programs.

Forum generates ideas for building support systems

Early on in this work, we wanted to sponsor a forum to brainstorm ideas about supporting clinicians who have been involved in an adverse event. In January 2004, MITSS hosted such an event with the gracious support of the Dana-Farber Cancer Institute (DFCI) and Jim Conway, who was then chief operating officer at DFCI. The program was entitled "Forum: Improving Clinician Support Systems for Adverse Medical Events."

Nineteen people attended the 1-day event: 5 were affiliated with MITSS, 4 of the doctors had been part of my code and care teams, and others were risk managers from Brigham and Women's Hospital and DFCI. There were also representatives from nursing and pharmacy. Two psychiatrists gave sobering presentations: Dr. John Fromson from Physicians Health Services (PHS), and Dr. Miguel Liebovitz, who worked with physicians being sued for malpractice.

The group discussed what could be done to support clinicians and suggested next steps. At the time, we were not aware of any institutions with support systems for clinicians following adverse medical events. We were disappointed with the forum's small turnout, but it was a beginning.

Searching for best practices

When planning the March 2009 forum, "Disclosure and Apology—What's Missing? Advancing Programs that Support Clinicians," I envisioned that by the end of the day, we would have discovered emerging best practices that organizations could use to develop their own clinician support programs. That goal proved overly optimistic; we did not leave the forum with a tidy list of policies to recommend. One thing we did learn is that support programs must be customized to reflect the culture of the institution; there is

no "cookbook" solution for this problem. We did, however, come away from the forum with the set of important recommendations below to help guide institutions as they develop these programs.

Over the years when I have presented at conferences, I have been overwhelmed by the stories clinicians have shared with me about their trauma following adverse events. It appears that nearly every clinician has experienced the emotional impact of an event of one kind or another. In many cases, the event still haunts them. Early on, the response I often heard after describing the MITSS program was, "That's nice; keep up the good work." The message has shifted, and now I often hear, "We need to do a better job supporting our staff; can you help us?"

It appears that the time is ripe for developing programs to support clinicians following adverse events. The 2004 MITSS forum provided questions and direction. At the 2009 forum, although we did not discover emerging best practices, we did capture considerable information about successes, barriers, and opportunities in this developing arena.

We also learned about a small number of institutions with established, successful programs, which provide several different models for clinician support. The following information from the forum is intended to help others build their own programs.

What have we learned?

All healthcare organizations should provide emotional support to clinicians and staff members following adverse events. The following list of recommendations reflects what we have learned from the experience and expertise of early adopters—pioneering healthcare professionals who have articulated the need for support and a small number of institutions that have implemented programs.

- **Programs may take many forms, but some kind of support should be made available for all clinicians and staff.** Programs should be established as soon as possible and publicized widely, so individuals will know how to access help in the immediate aftermath of an event.

- **Clinician and staff support should be part of each institution's operational response to adverse events.**

- **Support programs must reflect each institution's circumstances and culture.** An institution may want to develop separate programs for different elements of the workforce. The kinds of programs that have proved helpful include: peer support (individual or group); employee assistance programs; and psychological and psychiatric counseling.

- **Don't assume that individuals whose involvement in the event seems peripheral will not experience stress and will not need support.** And don't pre-judge what constitutes an adverse event. Managing these programs successfully means being observant and flexible about the needs of different individuals.

- **Pay especially close attention to clinicians involved in disclosure and apology discussions following adverse events.** They may have urgent needs for support and may engage with patients and families more effectively if they, too, feel supported.

- **Support programs will not be successful without visible commitment from the institution's executive and medical leadership.**

- **Fear of legal action should not prevent someone from getting the emotional support they need following an adverse event.** While clinicians should avoid discussing the details of the medical case and event outside of privileged communications with legal counsel, they may talk about their feelings without fear that those discussions will be used against them in court.

- **Clinician support programs may be characterized as protecting an institution's investment in its workforce and supporting favorable return on investment.** At this early stage, there is not much data available to support the business case for support programs, but a case can be made based on anecdotal evidence and common sense.

MITSS will continue to contribute to awareness and development of programs that support clinicians and staff members following adverse events. The individuals, institutions, and organizations that participated in the March 2009 forum helped advance this issue with their honest and generous contributions. **NPSF**

Linda K Kenney is president and executive director of Medically Induced Trauma Support Services (MITSS) in Chestnut Hill, Mass. Contact her at lkenney@mitss.org.

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2010 NPSF Congress Debuts Simulation Program

Join patient safety leaders from across health care at the 12th Annual NPSF Patient Safety Congress, May 17–19, in Orlando, Fla. This year's event features the debut of the Learning & Simulation Center, an innovative educational setting using simulation to depict realistic scenarios of healthcare settings in the context of patient safety.

Demonstrations using a variety of simulation modalities will create unparalleled educational opportunities for attendees and transform the exhibit hall into a lively, engaging learning environment. The Congress also will offer 35 in-depth breakout sessions, interactive full-day Pre-Congress programs, motivational plenaries by healthcare leaders, and the popular Breakfast Roundtables.

PRE-CONGRESS PROGRAMS: Monday, May 17

Interactive programs offer opportunities to learn from patient safety experts and to share and innovate with peers.

- **Leadership Day**—Created exclusively for C-suite and board level participants to explore the executive-level role in improving safety.
- **Community Engagement from the Patient & Family Perspective**—Developed to provide models for partnership for the community, patient and family representatives, and healthcare workers.
- **New! Measurement Boot Camp**—A half-day deep dive into measurement programs designed to evaluate the effectiveness of patient safety efforts.
- **New! Simulation Fundamentals to Advance Your Patient Safety Agenda**—A half-day program on applying simulation in health care, with demonstrations and discussion.

BREAKOUT EDUCATIONAL SESSION TRACKS: Tuesday–Wednesday, May 18–19

Best Practices, Delivering Solutions

- Behaviors and Cultural Attributes That Drive Performance
- Harmonizing and Integrating Operational Practice with Policy and Regulatory Mandates
- Implications of Health Reform for Patient Safety
- Enhancing Process Reliability and Safety
- Managing Complex Care Across the Continuum
- Managing Crowding and Overuse of Services: Implications for Patient Safety
- Hot Topics

For a complete listing of sessions and online registration, visit: *http://www.npsf.org/npsfac/index.php* NPSF

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Healthcare-Associated Infections: Applying Patient Safety Solutions to Emerging Liability Challenges. This series, complimentary for members of NPSF's Stand Up for Patient Safety program, will explore infection prevention and control from a patient safety and risk management perspective, identifying effective strategies that organizations have used in their efforts to reduce healthcare-associated infections.

Apply for the Patient Safety Leadership Fellowship by February 15

The AHA-NPSF Patient Safety Leadership Fellowship, now in its ninth year, is a year-long transformative learning experience that arms participants with critical knowledge and tools, as well as the leadership skills necessary to extend their influence, build allies, initiate and sustain improvements, and help create a culture of safety in their organizations.

The Fellowship unites the strength and resources of its co-sponsors and partners—the American Hospital Association (AHA) and NPSF, the Health Research & Educational Trust, Health Forum, the American Organization of Nurse Executives, the American Society for Healthcare Risk Management, and the Society of Hospital Medicine.

Applications are due by February 15. For more information, visit *www.ahafellowships.org* or call 312-422-2933. NPSF

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