

The Continuous Patient

Case Studies for a Patient Moving Through the System



MISSION:

Michigan Department of Health and Human Services (MDHHS) provides opportunities, services, and programs that promote a healthy, safe and stable environment for residents to be self-sufficient.

The Patient Experience

- Patients experiencing an emergency enter the healthcare system with specific needs related to acuity of care, timeliness of interventions, and the need for safeguards.
- The transition from injury/illness ➡ EMS ➡ emergency room ➡ transfer to tertiary care requires caregivers to communicate clearly and thoroughly.
- Caregivers must utilize best practices during patient handoffs, trying to listen to the information shared and asking questions to ensure the patient is not placed in risk.

Patient Handoffs

- The National Association of EMS Physicians defines the patient handoff as: *“the transfer of information, professional responsibility and accountability between caregivers.”*
- Patient handoffs are a **critical component** of quality patient care and have enormous influence on patient movement within the clinical environment.
- Failures of communication during transfer of patient care are major drivers of error and patient harm within the current healthcare system.

Starmer, A. J., Spector, N. D., Srivastava, R., West, D. C., Rosenbluth, G., Allen, A. D., ... & Lipsitz, S. R. (2014). Changes in medical errors after implementation of a handoff program. *New England Journal of Medicine*, 371(19), 1803-1812.

Patient Handoffs

- There are many reasons, handoffs between prehospital and in-hospital clinicians are logistically difficult and vary in quality.
- For EMS:
 - The ER may have a disorganized process that inhibits the EMS provider's ability to act as patient advocates while sharing information.
 - This may be due to a rushed staff, with multiple areas of focus.
 - Lack of standardization regarding handoff procedures and information shared.
 - Lack of knowledge regarding the quality and accuracy of information provided by the EMS provider.

Patient Handoffs

- For Emergency Department Staff regular handoffs can be affected by:
 - Regular interruptions and the chaotic environment of the emergency department.
 - Interruptions leading to information loss and negative impacts on patient care.
 - Lack of a standard handoff tool between EMS and hospital providers.

How Does this Affect the Patient Experience



Accurate and thorough communication during the patient's interaction with the health care system, helps to ensure patients receives quality care.



A study in the June 2020 edition of the International Journal for Quality in Health Care found that:



“Effective communication can have a profound impact on how patients and caregivers perceive their care...patients consider poor communication to be one of the main causes underlying diagnostic error.”

Let's Talk About Patients

- With all this in mind we would like to give examples of possible patient experiences.
- We would like to look at the journey through the healthcare continuum for patients experiencing medical and/or traumatic events.
- During these case studies we want you to think about how the patient experience could have been improved.

Trauma Tim

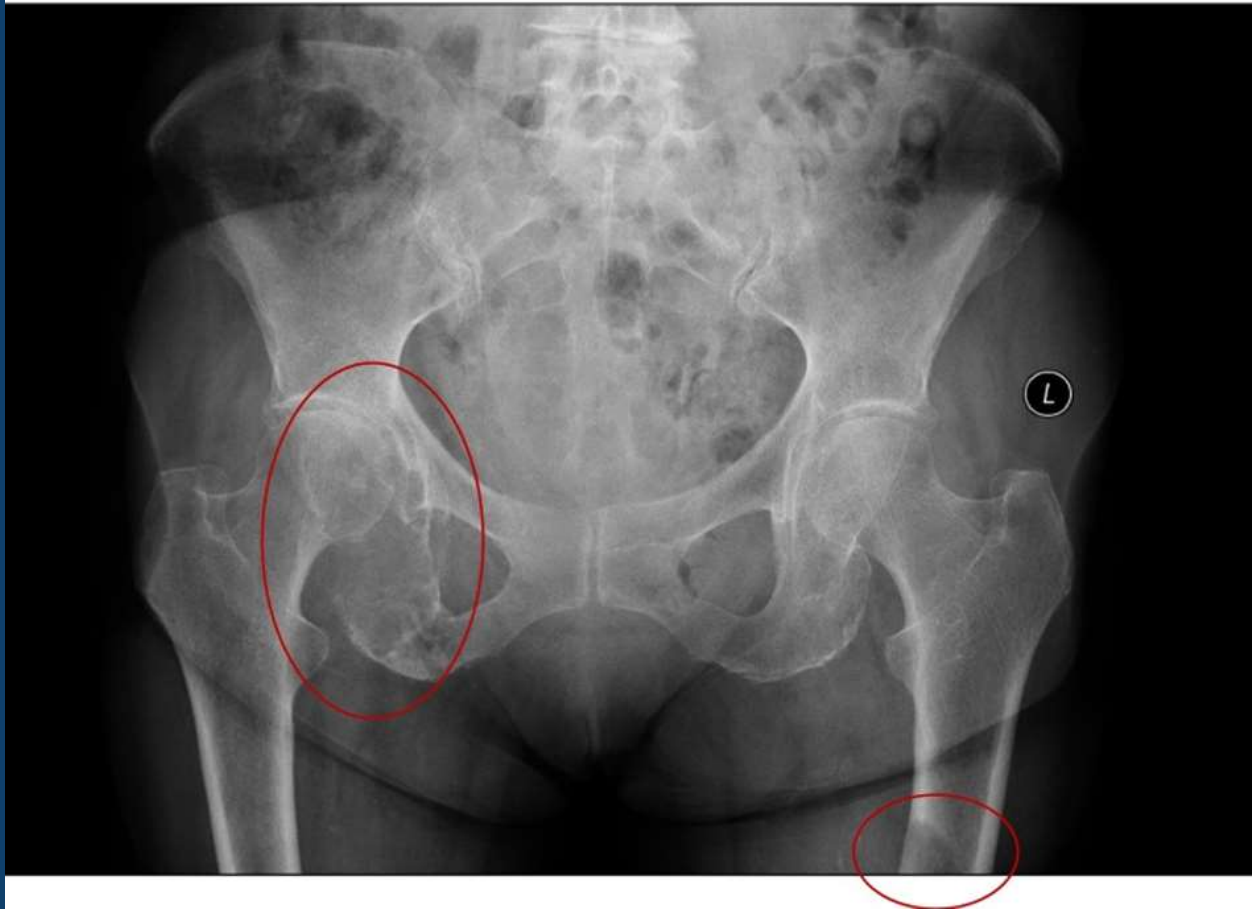
- Tim is a 68-year-old male who has an extensive honey-do list on a windy Saturday in October.
- He was on a 10-foot ladder cleaning the gutters, when a gust of wind caused him to fall off the ladder onto the ground taking out his wife's prized Azalea bush.
- Tim has a history of atrial fibrillation and takes Eliquis.
- It is unknown how long Tim went before being found and if he lost consciousness.
- EMS arrives and does a complete assessment and finds a questionable injury to the pelvis and some mild confusion leading to concern of head trauma.

Trauma Tim

- EMS determines Tim needs a trauma center evaluation. His vital signs are WNL and the closest trauma center is their rural Level IV facility.
- Tim and his wife prefer to stay closer to home if they can.
- EMS calls the Level IV Trauma Center and gives report. Focusing on the stable vital signs and patient preference the ER staff tells EMS to bring them in.
- EMS arrives thinking this patient would be a trauma activation and is not.

Trauma Tim

- Once in the ER the EMS providers ask why he is not a trauma activation – staff says the medic giving the report sounded calm and they didn't think he needed all chaos of a trauma activation.
- EMS repeats their initial findings of questionable pelvis injury and mild confusion post fall of someone on thinners.
- ER staff felt the patient appeared to have a GCS of 15 now and didn't really seem to be in a lot of pain so they would evaluate.
- EMS, frustrated, turns the patient over without further discussion.



- After 2 hours in the ER Tim received a CT scan and x-rays which showed a small subdural bleed and a pelvic rami fracture.
- Tim would now will be transferred to a higher-level trauma center to monitor his subdural bleed.

Trauma Tim

- How could EMS have communicated better?
- How could the ED staff ensured correct information was collected?
- Once there was and identified communication breakdown, how could it have been corrected?
- What are the concerns for patient care and safety?

Pediatric Patty

- EMS is called to the home of 2-year-old Patty. Her parents are concerned that something is not right with her and she needs to go to the hospital.
- Patty's parents explain she has been recently sick with the "flu" going around, some nausea and vomiting, but today she seems really off. She just doesn't seem to be responding to them like she normally does.
- Patty is pink, a little flushed and skin is dry. She is mildly tachycardic. She doesn't seem interested in the paramedics; she appears to be looking at her mom.

Pediatric Patty

- EMS determines she is probably just a little dehydrated and that her parent are tired and overreacting, despite the parent's instance she is “not right”.
- They decide to take her into the local ER.
- They call the ER with this information and upon arrival are directed to one of the lower acuity rooms away from the main nurse's station.
- They give report to the nurse and due to the lack of emergence in the communication, the nurse enters information into the computer before doing her assessment.

Pediatric Patty

- Once the nurse starts the assessment, she realizes the child isn't staring at her mother but is having a seizure.
- Because they are in a low acuity room, she does not have the monitoring and equipment she needs.
- Once the parents are notified of what is happening, they are upset because "we tried to tell you guys something wasn't right"



- What could EMS have done differently when communicating with the parents?
- How could the ED staff responded differently to the parents' concerns?
- Once there was and identified communication breakdown, how could it have been corrected?
- What are the concerns for patient care and safety?



Bypass Betty

- Betty is a 94-year-old lady who lives in assisted living.
- When staff came in to bring her breakfast they found her sitting on the floor confused.
- She has some mild dementia, but is generally oriented to person and place.
- EMS was called.

Bypass Betty

- When EMS arrived, they were concerned she may have had a stroke and told staff they wanted to take her to the larger hospital 30 minutes away. The local hospital is not a stroke center.
- Staff was very concerned about this because Betty's daughter is 75 and doesn't drive, so it would be difficult for her to get to the hospital. Betty gets can get agitated when out of familiar surroundings and without her daughter.
- They said she has had a history of UTIs and thought that might be the cause of her troubles today.

Bypass Betty

- EMS was focused on the confusion and the fact Betty had a stroke. Facility staff asked about checking a temperature or blood glucose, but their request was ignored.
- Betty was transferred to the larger stroke center for a stroke alert. Her exam, labs and CT determined she had a UTI and early sepsis.
- Betty had to be sedated during her evaluation due to severe agitation.
- After speaking to Betty's daughter, Betty was transferred back to the small local hospital where her daughter can visit.



Bypass Betty

- What could EMS have done differently when communicating with the facility staff?
- How could EMS have responded differently to the caregiver concerns?
- Was there an opportunity to speak to the local hospital before bypassing?
- What are the concerns for patient care and safety?

