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Synchronized Ongoing Support:

An integrated response to unanticipated outcomes

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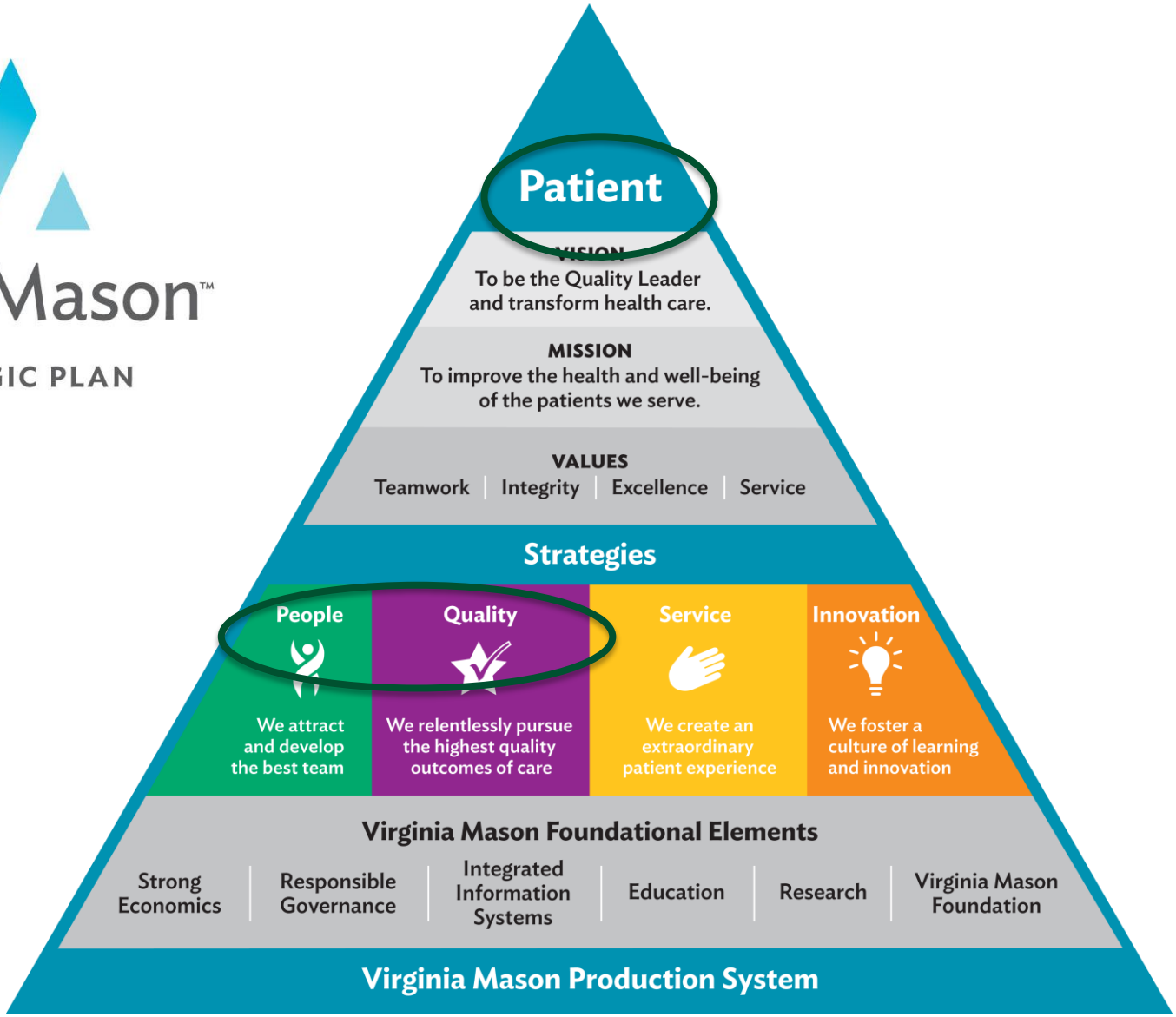
Virginia Mason™

Each Person.
Every Moment.
Better Never Stops.

Virginia Mason™

OUR STRATEGIC PLAN



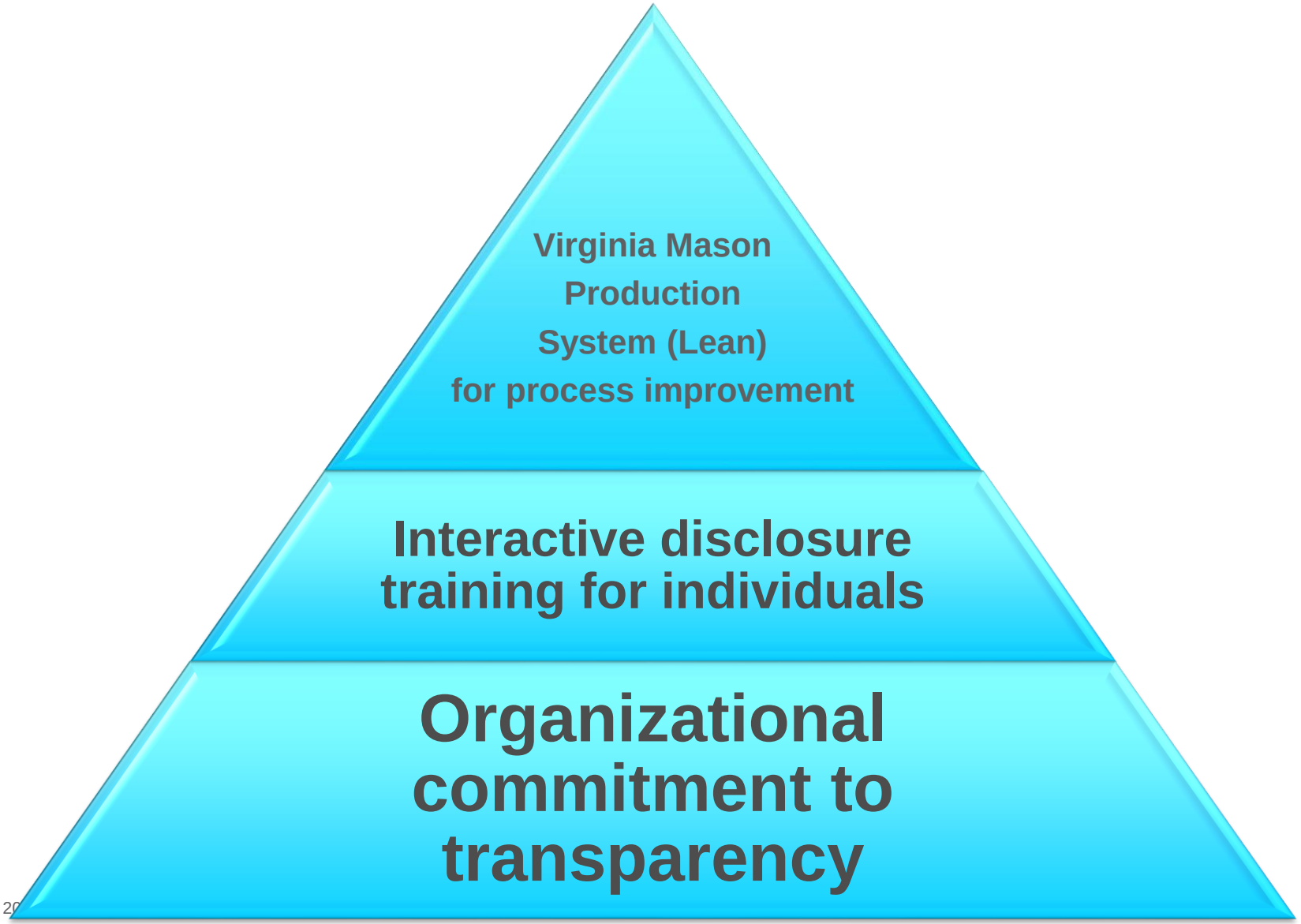
Objectives

- **Share the Virginia Mason definition of unanticipated outcome**
- **Engage stakeholders in development and ongoing improvement of integrated response to unanticipated outcomes**
- **Learn how to compassionately meet the needs of patients & families**
- **Understand the need for providing support for team members**

The Perfect Patient Experience

2011 3P Vision: Safety in Action

Foundation of Improvements



VMPS (Lean) events

Organizational 5 day

- Basic SOS Process Developed
- Lead time decreased from event to notification

Organizational 2 day

- Guiding principles of team support identified
- Workforce distress addressed

Organizational 5 day

- Focus on patient voice & experience
- Collaboration between Patient Relations & Patient Safety
- Patient advocate available 24/7

Why?

"What we needed was for someone to reach out and be human, be real and talk to us."

- a family member

"How do I tell them? I don't even know what happened yet, what if they blame me?"

- a provider

"You began with "I am sorry," and after that, I could listen because I knew you cared."

- a family member

What is an SOS?

(Synchronized Ongoing Support)

Help when you need it most.

SOS: When & Why

Dial 0 for a:

- Major unexpected clinical outcome
- Major immediate family needs
- Urgent non-clinical support needs

Why?

Early initiation of psychosocial support and safety improvements helps patients, families and staff

SOS: What to Expect

Who? Anyone can call

What happens?

- Conference call with on-call Patient Safety & Patient Relations team
- Just in time provider coaching for communication with patients & families
- Patient advocate present with provider for acknowledgement
- Support for team & safety concerns

Patient & Family Support

It was not the parking passes, it was not about food, it was about having ***someone being there and supporting us***. Letting us know when there was information and when there was not and if not, when there would be. It was about a single point of contact. ***Knowing someone cared just about us*** while everyone else worried about Tony. She knew when to talk and when to just sit silently with us and be there. ***- Family Member***

Supporting the Patient & Family

- Value proposition – true value of this support
  - Patients and Families tell us it is not about the parking vouchers, the meal vouchers or the cup of coffee, it's about
    - Someone who is listening
    - Someone to help you think about what you need to do next
    - Someone who can just be with you
    - Someone who can explain what happens next

Acknowledgment Meeting

Essential Elements

- Acknowledge
- Empathize
- Apologize
- Review/Follow-up
- Introduce Advocate/Exit

Team Support

I was pleased to see the SOS Response Team in the hospital immediately after the incident. This was after regular business hours and I did not expect this kind of team and family support at such a late hour. I feel this was going above and beyond for our team members. ***- Provider***

Team Support

- Debriefs & ongoing support:
  - Local leaders
  - Internal Support Resources
  - Employee Assistance Program
  - 1:1 and Team Support

Safety & Service Improvement

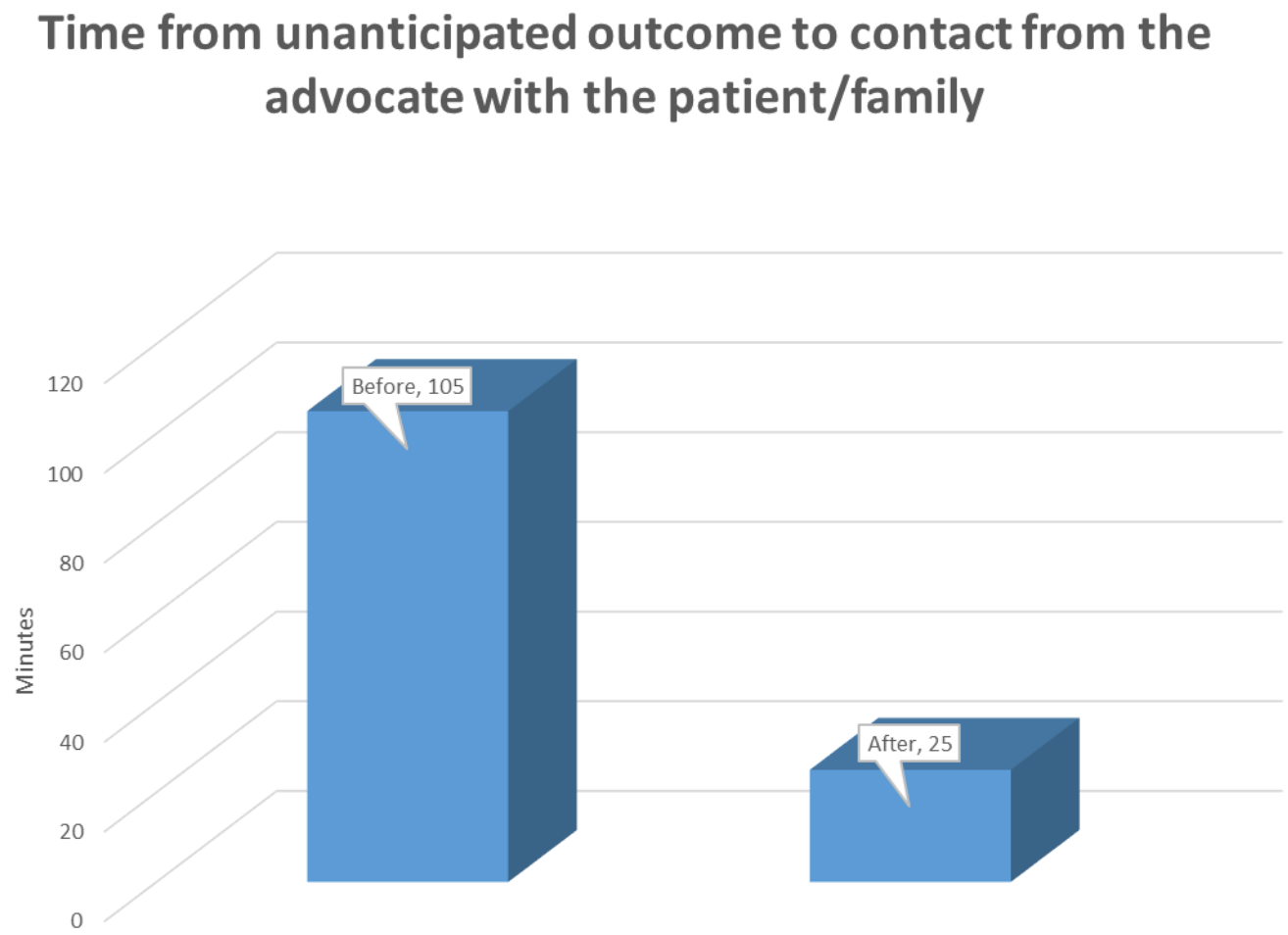
Everyone who came “walked in the shoes” of the all the staff involved: from when the MD writes the orders to when it is given by the nurse. It makes me very proud to be a part of this organization.

- Nursing Unit Director

Safety & Service Improvements

- Debrief between Patient Safety and Patient Relations responders
- Identify areas of improvement or best practices for patient safety and service
- Share with stakeholders, reporter(s), frontline and Executive Leadership

Measured Outcomes



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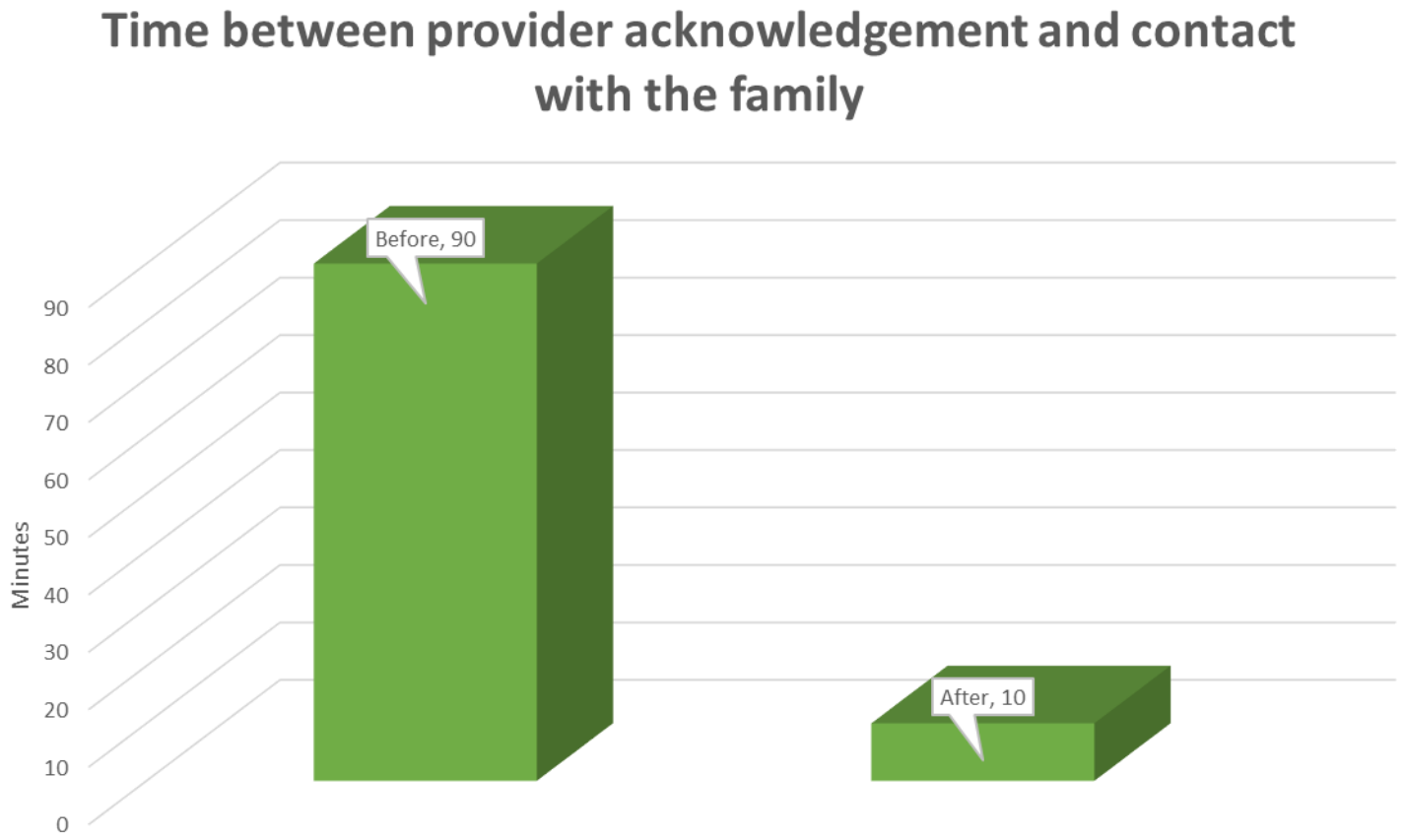

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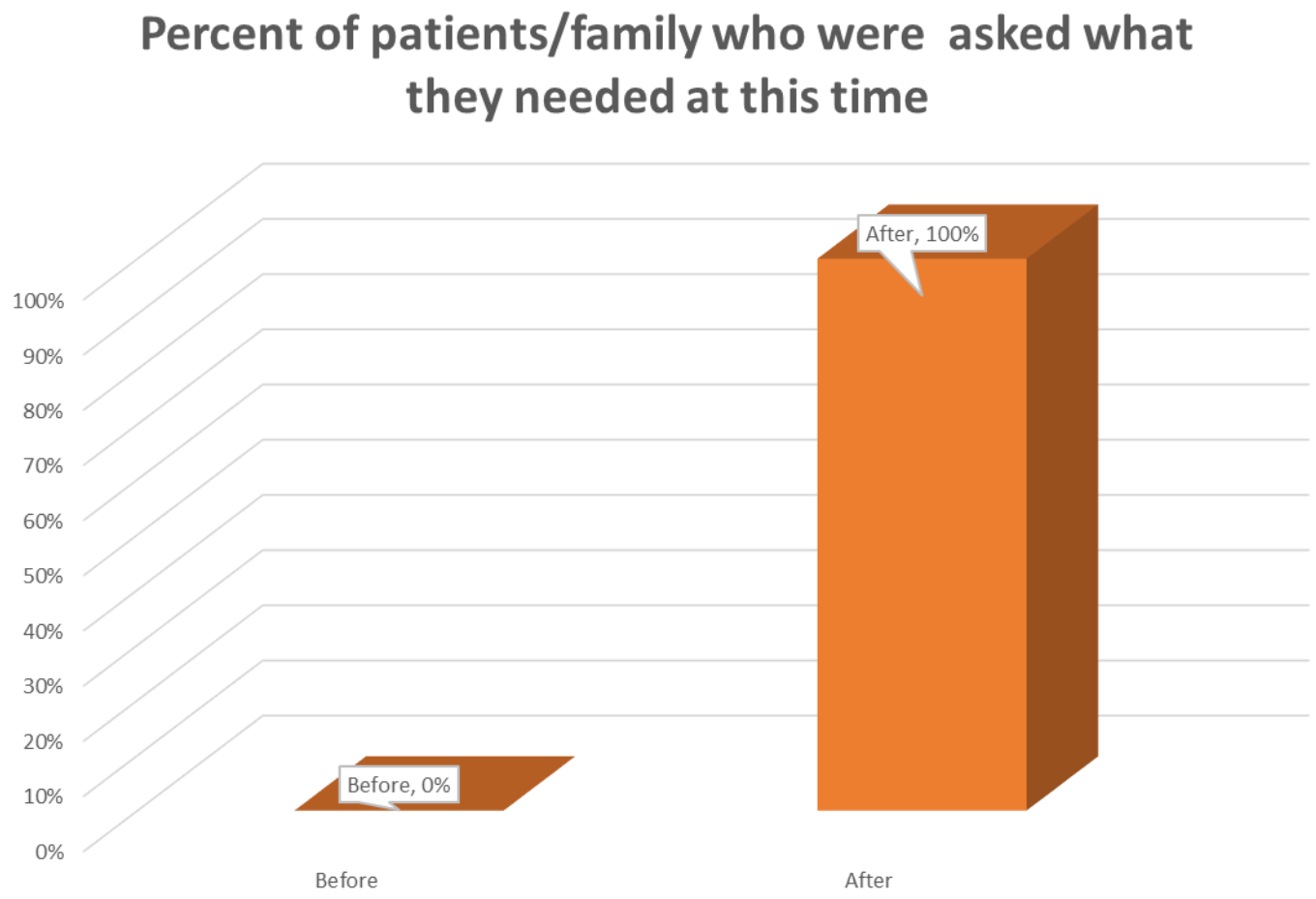

Lessons Learned

- Early stakeholder engagement
- Keep it simple
- Communicate widely
- Drills increase comfort
- Listen: to patients, families, & team members
- Continual process improvement

Video

Questions & Discussion

Table Discussion

1. Would you say that your organization is ready for transparency and disclosure?
2. What support do you currently have in place for patients, staff, and/or providers?
3. What is the biggest barrier you envision for implementing a program like SOS in your institution?
4. What would you most like to see provided to patients and/or families after an unanticipated event?)