Helen Mason

Healthy, thriving communities, Kia Momoho Te Hāpori Ōranga.

CARE Manaakitanga

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In November last year, I undertook an Observorship at Johns Hopkins Hospital in Baltimore, USA. It has world-renowned experts in patient safety and quality. This provided an opportunity for me to deepen my understanding of patient safety and quality, and learn what a world leading organisation is doing to ensure they are providing the very best care they can to their patients.

What was immediately interesting to me was the story behind how Johns Hopkins came to be on its patient safety and quality journey. It is a story which illustrates the importance for us, as healthcare professionals, of listening to patients and their loved ones, and keeping an open mind.

In 2001, 18-month-old Josie King died of dehydration, an undiagnosed central line infection and a wrongly-administered narcotic at Johns Hopkins. Josie was initially admitted with bad burns but had recovered well in the Paediatric ICU to the point where she was moved to the Paediatric Ward. It was from this point on that, despite Josie's mum Sorrel raising persistent concerns that something was not right with Josie and her treatment, she was largely ignored. It was a situation which had tragic consequences.

Josie's full story can be found in the link below:

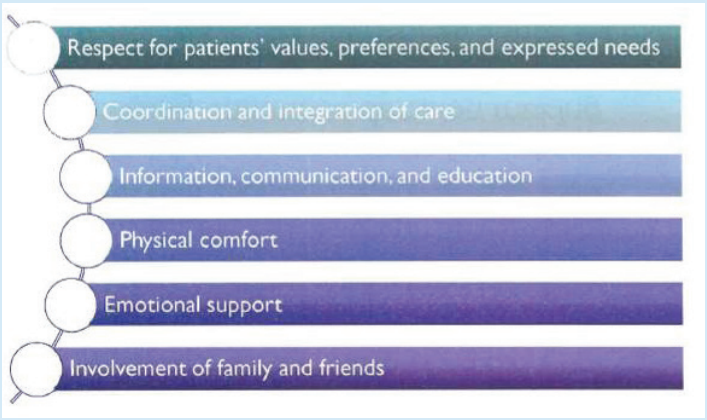
https://patientsafetymovement.org/advocacy/patients-and-families/patient-stories/josie-king/

Following her daughter's death Sorrel sought assurances from Dr Peter J. Pronovost, Medical Director of the Quality and Safety Research Group at Johns Hopkins, that a similar incident could never happen again. Dr Provonost could not give that assurance. Sorrel felt that was unacceptable and ever since has been a passionate advocate for patient safety and patient centred care. She works closely with Peter Pronovost to support Johns Hopkins on its going journey to improve patient safety.

To Johns Hopkins' credit they used the Josie King case to take a long look at themselves and their procedures. As a consequence of that, and the hard questions and hard work which followed, they put in place systems to safeguard patient safety and are now globally-recognised patient safety experts, under the banner of the Armstrong Institute.

Patient and family-centred care and participation

A key plank of the Johns Hopkins' approach to achieving patient safety is patient and family centred care and participation. At John's Hopkins, patient participation is referred to as patient activation. They describe patient activation as "understanding one's role in the care process and having the knowledge, skills and confidence to take on that role.



As part of own focus on patient and family-centred care at the BOPDHB, we have been invited by the Health Quality and Safety Commission (HQSC) to work with them on its Patient Deterioration programme. More information on this programme can be found at:

https://www.hqsc.govt.nz/our-programmes/patient-deterioration/

As part of this programme a structured framework is being developed around how family and whānau can escalate concerns about a deteriorating patient. I look forward to seeing how this work progresses.

Our BOPDHB

In our CARE values, we have our value around "All-one-team". We need to make sure that our patients and their loved ones are part of that team. We need to ask ourselves if we are really listening to our patients, their whānau and family members when they say something isn't right. It allows us to investigate earlier and, most importantly of all, could lead to better outcomes for our patients.

"Slow down and take your eyes off the computer screen.
"Look at the patient in the bed and listen.
"Listen to the mother who is saying something is wrong."

Sorrel King – Josie King's mum