Red Card Event
Peninsula Regional Medical Center

Program/Project Description.
We initiated and completed the TeamStepps training program in the Emergency Department at PRMC in 2010.

This program was well received and there was strong belief was that this effort was excellent in improving teamwork and cementing patient safety as a top department goal and focus. One of the issues that became evident, however, was the issue of poor communication among team members. It became increasingly evident with each case review that we conducted that the physician's view and information regarding an event was many times vastly different from that of the nurse or other emergency department staff members. Out of this discussion, there became the desire to not only have a process to speak up with a patient safety concern, but to also have the ability to have an immediate halt, attention, communication and group consensus reached regarding the safety concern raised.

Some of the baseline data utilized in support of this opportunity for improvement came from the NRC Picker scores around the impression that the physician and nurse both understood the plan of care and shared this with the patient.

Process.
This solution came out of discussions and brainstorming between the ED leadership team building on the principals of TeamSTEPPS that we learned as part of the TeamSTEPPS train the trainer course. The concept of hardwiring for sustainability was key in developing a hands on tool for staff and physician use without conflict and placing the patient first as a team.

Education was done with all key stakeholders and examples of events were reviewed. The charge nurse group was supported by management and reviewed the process continually to mark importance. The process encompassed the eight stage change process by John P. Kotter. The fifth stage where empowering broad based action where one changes systems and encourages risk taking and nontraditional ideas, activates and actions, and finally reaching the eighth stage over a period of time as we anchor new approaches in the culture.

Solution.
In response to the question of “How do we stop the line for patient safety,” we developed the solution of a Red Card Event. A Red Card event is a process where any member of the team, in the circumstance of continued disagreement despite communication with the tools of CUS and DESC over a patient safety concern, can pull and present a Red Card. This action immediately halts any further patient treatment around the safety concern and mandates that the charge nurse and charge physician, and the department manager if available, along with the initial participants, huddle to examine and discuss the issue and form a consensus regarding the safest course of action for the patient prior to treatment being restarted. A poster of the process was posted in the department, laminated red cards were placed in all the treatment areas, and this process was rolled out to the department as part of TeamSTEPPS module of Mutual Support. It was stressed that a Red Card is not a punitive event, but rather an opportunity for communication and real time improvements in patient safety.

Measurable Outcomes.
We believe this process has had multiple benefits regarding patient safety. One, this tool empowers members of the team toward patient safety. They know that if they have a concern, and they do not believe that their concern was adequately addressed with initial proper communication steps at the basic team level, their concern will be heard and addressed by leadership within the department; a cry out for patient safety will be heard. Secondly, this process allows additional input when two members or more members of the team are unable to reach an agreement on the safest course of action regarding a patient. And third, this process allows a solution to patient safety issues to be to reached in real time so that the solution benefits the actual patient with whom it was raised; this changes should have done, to did.

Employee engagement survey results were as follows:
- Question - When safety is at risk or medical errors occur, management can be counted on to take the proper action - 81.2% positive
- Question - In this unit we discuss ways to prevent errors from happening again - 87.5% positive
Sustainability.
For the Emergency Department, a poster of this process is permanently located at the main desk along with laminated cards at every treatment pod. We log every red card event that happens and these events are reviewed by the department at our monthly meetings for department patient safety improvement opportunities. (see attachments)

The organization is evaluating the spread to critical care areas and initiation on our two demonstration units currently implementing CUSP programs based on the John Hopkins model. Organizational leadership has been given overall presentations of process, changes and current results and staff input about our journey to safety.

Role of Collaboration and Leadership.
The TeamSTEPPS Program implementation was a day educational opportunity for the emergency department at PRMC. Through the communication of elements of team structure, leadership, situation monitoring, mutual support and key communication tools, collaboration with the goal of patient safety was unveiled as a shared mental model development concept.

The emergency department is comprised of one hundred seventy people including thirty-five providers, both physician assistants and ED physicians. The emergency department has also collaborated with the respiratory department and radiology and incorporated those departments into the TeamSTEPPS teaching and concepts; empowering them to participate and speak up as well. The leadership, including the CEO, COO, VP for Quality/Safety improvements and VP of patient care services were very supportive. Through leadership rounding, receiving frequent updates by ED leadership and championing favorable results from employee engagement safety perception data, executive staff is very engaged and visibly supportive.

The emergency department leadership conducted module training sessions where 5 classes of each module were offered during each month for effectiveness with such a large group of staff. Support was demonstrated by highlighting processes of daily huddles, recognition of safety stories and supporting staff when concerns were voiced with quick responses and real time feedback.

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Patient Safety: Red Card Events

Speak Up...

A constructive approach for managing and resolving conflict

D—Describe the specific situation
E—Express your concerns about the action
S—Suggest other alternatives
C—Consequences should be stated
Still feel Uncomfortable?

RED CARD EVENT
Ultimately, consensus shall be reached.

RED CARD EVENT

Criteria
Immediate Team Huddle with Primary RN, Treating Provider, Charge RN, Charge Doc, other staff involved and Manager (if available).

1. Problem solving
2. Use chain of command and resources as necessary
3. Ultimate consensus shall be reached regarding safest outcome for patient
4. Team Event sheet completed.