■ビデオレクチャー

日本の医療者の皆さんへ ～ジョージィ・キング財団が進めてきたこと

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4 人の子どもを育てる専業主婦だったが医療事故で末娘ジョージィをなくす。その後、事故に対する和解金をもとに財団を設立し、医療の安全を推進するための活動をおこなっている。娘の事故の経緯を話した講演 DVD は数千の医療機関で上映され、大きな反響を呼んだ。患者側も緊急の対応を要請できる〈早期対応チーム(RRT)〉、入院患者の医療参加を支援する〈入院日誌(ケア・ジャーナル)〉、医療従事者の心理ストレスを軽減する〈医療者への支援(ケア・フォー・ザ・ケアギバー)〉プログラム、〈看護師日誌(ナース・ジャーナル)〉、教育プログラム〈患者安全カリキュラム〉などさまざまなツールならびにプログラムを開発。全米各地の病院に導入をすすめている。その功績が称えられ『ウーマンズ・デイ』誌の「2010 年 世界を変える 50 人の女性」に選ばれた。

こんにちは。日本の優れた医療従事者の皆様、お会いできて大変嬉しいです。医療安全全国フォーラムに参加できず申し訳ありません。でも とても感謝しています。私とジョージィ・キング財団のメッセージを こうやってお届けできますから。

娘ジョージィが医療事故で亡くなって 15 年以上たちます。事故は米国最高の病院で起きました。その和解金をもとに作ったのがジョージィ・キング財団で、娘の死が素晴らしいことをもたらしています。財団のプログラムの現状について、ぜひご報告させてください。

財団ではどのプロジェクトも、どのプログラムも、すべて文化とコミュニケーション、そしてチームワークに焦点を当てています。ひるまず声を上げるよう医療従事者を促し、患者と家族の声に、互いの声に、耳を傾けるよう促しています。

98,000 人が毎年医療事故で亡くなります。米国で 4 番目に多い死因で、ジャンボ機が毎日墜落するのに匹敵します。状況は良くなっていますが、まだ先は長いです。

お話したいプログラムの一つが「家族が呼べる早期対応チーム」です。通常「コンディション・ヘルプ」と呼んでいます。「10 万人の命を救え キャンペーン」をきっかけに、数年前に生まれました。その理念は 「患者中心の医療」で、全国の病院が導入しています。全く新しいシステムだと評判です。

実施の大きな妨げになったのが、患者と家族によるシステムの濫用をどう防ぐかという問題でした。リモコンを落とした、食事がまずい、看護師が変な顔をした、と言って通報されたら困ります。

やがて、患者と家族を教育すればよいとわかりました。いつ呼ぶか、どう呼ぶか、はっきりさせるのです。家族が早期対応チームを呼ぶ、このシステムは大成功を収めています。

私が学んだのは 病院がこういうシステムを導入しても、そのための文化がなければ成功しない、ということでした。すべての看護師、すべての医師がその文化を望み、指導者がシステムの早期導入を訴え、患者と家族も導入を求めます。こうして文化が生まれてから、システムを適切に導入するのです。

もう一つ、数年前に始まったのが「入院日誌プログラム」です。入院日誌は簡単な小さなノートで、30 日用と７日用があります。患者と家族が入院中に考えを整理するのに役立ちます。ちょっとした空欄に、毎日の記録、駐車スペースの番号、担当の先生や看護師さんの名前をメモできます。日々の目標とか、薬、手術、処置、検査のことなど、医療従事者に聞きたい大事な質問も書いておけます。

最初はちょっと大変でした。この入院日誌を、私と財団から患者と家族に贈るつもりだったからです。しかしその後、これはただの日誌ではないと気づきました。患者と家族に、看護師や医師から手渡せば、医療側と患者側の間の断絶に橋をかけるのに役立ちます。

全国の病院が独自のラベルを入院日誌に貼っています。

「デューク大学医療センターへ ようこそ。この日誌を差し上げます。治療のパートナーになって、声を上げ、遠慮なく質問してください」

入院日誌は成功しています。断絶に橋をかける素晴らしい手段で、医療側と患者側が信頼で結ばれ、良い関係を築くことができます。

「ジョージィ・キング DVD」は最初に作ったプログラムです。正確には二番目ですね。13 年以上前のことです。

これはジョージィの物語の DVD で、３つの言語に翻訳され、世界中に届けられています。医学部、看護学校、病院、診療所、航空業界で使われています。法科大学院でも、です。

何年もかけてわかったのは、残念ながらデータやスライド発表、統計の力には限界がある、ということです。本物の人生の物語しか、変化を起こせる医療従事者のような人びとの心と頭に届かないことがある。

ジョージィの物語は、世界中の医療従事者を励ましています。耳を傾け、声を上げ、チームワークと文化を改善し、患者と家族の声を聴き、ベッドの患者を見て、母親の話を聞くように、と。

DVD の注文が殺到しています。ひっきりなしに…。素晴らしいです。このとき病院は財団に寄付しますが、そのお金は医療産業に戻ります。お話したプログラムの形で、ですね。

これらのプログラムはどれも使いやすく 基本的です。コミュニケーション、チームワーク、患者中心の医療に重点を置いています。

もう一つ手短にお話したいのは、「医療者への支援プログラム」です。娘の事故の２年後に気づきました。第一の被害者は患者と家族ですが、第二の被害者がいて、それは医療従事者だと。それは看護師 医師など医療従事者で、有害事象に関わった人たちです。全国の病院を回る中で、この人たちの苦しみを知りました。

第二の被害者を放っておいたら、問題がたくさん起きるでしょう。そして医療産業には第二の被害者への支援が全くないことも、わかりました。

第二の被害者のために看護師日誌を作りました。まず看護師です。小さな日誌で、有害事象によるストレスや看護の仕事のストレスに対処する助けになります。

「医療者への支援」に関しては、今は これだけですが、１月に もう一つ立ち上げます。お楽しみに。またご報告します。これもすごいですよ。幸せにするプログラムです。３ヵ月間のプログラムを通じて、医療従事者に幸福で健康になってもらいます。詳しくお話できませんが、現在開発中です。

ずっと医療産業に関わってきて、気づいたことがあります。医療従事者から よく聞かれます。
「この勢いをどう維持しますか？」
「患者安全にエネルギーを注ぎ続けるには？」
「開かれた透明性の高い院内文化をどう醸成しますか？」
「看護師と医師、職員に、ニアミスに気づかせ、事故を避けるには？」
「ニアミスに気づいて報告し、話題にし、学ばせるには？」
米国の医療産業では文化がまだ育っていません。ニアミスについて気兼ねなく話せるような文化がないのです。
病院もいろいろ工夫しています。事故を防いだ職員にスターバックスカードを贈るとか、寒冷地の病院は 病棟に近い駐車スペースを提供しています。職員を表彰する病院もあります。
当財団は、特別で意味あるものを作りたいと思いました。ニアミスを報告した勇気ある医療従事者のために、です。ニアミスでなく「お手柄」と呼びたいですね。「お手柄」を見つけ、話題にし、教訓を得た職員のため、財団が作ったのは「ジョージィ・キング ヒーロー賞」です。記念の盾、きれいですね。
各地の病院がささやかな場を設け、お手柄だった看護師、医師らに、毎月この特別に意味ある賞を贈っています。それは、これまでに患者安全には本物のヒーローが必要だとわかったからです。

『ジョージィの物語』は６年前に書きました。太平洋を越えた日本で翻訳され、大変光栄で 感激しています。日本の医療産業の皆様に読んでいただけますから、皆様の励みとなれば幸いです。広く読まれていると聞き、喜んでいます。
本書を米国で出して以来、毎年４月に封筒が どっと届きます。全国の看護学校、医学部、病院からで、感想文が大量に入っています。看護学生、医学生、病院職員の皆さんが書いた感想文です。本書が必読書になっていて、課題は読後に、私に手紙を書くことです。テーマは 「医療従事者の卵としてどんな影響を受けたか」です。励まされますね。山のように いただいています。
つまり、こういう手紙を読むと、よくわかるんです。本書が医学生や看護学生の意欲を引き出し、教え導いている。教材として使われているのです。
当財団がデューク大学と提携し、その支援を得て作り上げたのが「ジョージィの物語　患者安全カリキュラム」です。柔軟にできており、16 あるステップをばらばらに使うこともできます。病院、看護学校、医学部で利用でき、このカリキュラムを動かす理念は非常に単純で、この言葉に集約されます。
「事実が知識をもたらし、物語が知恵をもたらす」
これが、このカリキュラムの肝です。私自身も感銘を受けています。全米に広がっており、いつか日本でも導入されたら嬉しいです。

この機会を借りて、日本の皆様に改めて御礼申し上げます。
ジョージィの物語が、皆様の心と頭にしみわたりますように。
米国の医療従事者のように、日本の皆様が本書から刺激を受け、新たな力を得て 患者安全の道を歩み続けてくださいますように。

声を上げることを忘れず、コミュニケーションを改善し、ともに患者と家族の声に耳を傾け、患者中心を堅持されますように。

患者中心という言葉、米国で流行っていますよ。

こうしてお会いできて光栄です。直接お目にかかりたかったです。良い仕事を続けてください。

ありがとうございました。

～ 原 文 ～

Josie's Story and Josie King Foundation
- Creating a Culture of Patient Safety, Together

Hello, to Japan and to all of the wonderful Japanese healthcare providers.
It's so great to be with you all via this video. I am really sorry and I'm sad that I can't be at the National Patient Safety Forum in person, but I'm really grateful that my message and the message of the 'Josie King Foundation' can be delivered to all of you through this video.
It's been over 15 years since my daughter Josie died from medical errors at one of the best hospitals here in the United States.
With settlement money from the hospital the Josie King Foundation was created and wonderful-wonderful things have come from her death.

I'm excited to be able to update you on some of the projects and programs that had been put in place at the Josie King Foundation. All of these projects, all of these programs are about culture. They are about communication. They are about teamwork.
They are inspiring our healthcare providers to never be afraid to speak up. They are about listening to the patient, listening to the family member, listening to each other.
98,000 people die every year from medical errors. It's the fourth leading cause of death in the country. It's like a jumbo jet crashing every day. Things are improving here in the United States, but I think we still have a long way to go.

One of the projects and programs that I want to update you on is the 'Family Activated Rapid Response Team' program. A lot of people call that 'Condition H' here in the United States. It was really inspired out of the 'Hundred Thousand Lives' campaign a couple of years ago and its essence, it's really about patient centeredness. Hospitals around the country have implemented it. They all call it something different.
One of the biggest hurdles I think when this was being rolled out was how do we prevent the patient and the family members from calling the rapid response team when that patient, that family member drops that remote control on the floor or when the food tastes bad or when the nurse has a funny look on her face.
What we've learned over the years is that the solution is to educate the patient, educate the family, make it crystal clear when to call, how to call.
Condition H, where the family activated rapid response teams had been a really great hit.
I've learned that when hospitals implement these programs or program like Condition H, it's usually not successful unless the culture is really ready for it.
The culture has to be where every nurse wants it, every doctor wants it, leadership is saying let's hurry up, let's get this program rolling, patients and families need to be demanding it, then the culture is ready, then the organization needs to do it like they really, really mean it.

Another really great program that's been in existence for a couple of years now is the 'Care Journal Program.' The Care Journal Program is it's a simple little booklet - there is the 30-day version and a seven-day version and it's just a tool to help patients and family members stay organized when they're in the hospital. There's a little place for them to write -- it's a daily sort of log, writing down their parking place, writing down the names of the doctors or the nurses who are caring for them, writing down their daily goals, the medications, surgery procedures, tests. Most important questions to ask where they write down the questions they want to ask the healthcare provider.
In the beginning, it was a little bit of a challenge because initially I was planning on this Care Journal Program that the physical care journal coming from me and the foundation to the patient and to the family member.
What we've since learned is that this tool is actually more than a tool.
If this tool is given to the patient or family member from the healthcare provider, from that nurse, from that doctor then this tool helps bridge 'the disconnect' between the healthcare provider and the patient and the family member. Hospitals around the country, they put their own special labeling on the Care Journal and the labeling says, "Welcome to Duke Medical Center.
This is a gift from us to you. We encourage you to partner with us in your care.
We encourage you to speak up. We encourage you to ask questions."
The Care Journal Program has been wonderful and it's just been a great way for hospitals to, like I said, "Bridge the disconnect" to build the trust to improve the relationship between the healthcare provider and the patient and the family member.

The Josie King DVD is probably our oldest program. It was actually our second program. It's been in existence for over 13 years.
The DVD is really just the Josie King's story. The DVD has been translated into three different languages. It's been shipped all over the world. It's been used in medical schools, nursing schools, big hospitals, little hospital - the aviation industry has used it.
Law schools are using it.
What I've learned over the years and what I know and what I have come to realize is that sometimes unfortunately it takes more than data, more than PowerPoint presentations, more than statistics – sometimes it takes a real life story to get into the hearts and into the minds of the people, the healthcare providers, who are going to turn this ship around.
Josie's story has inspired healthcare providers all around the world. Her story has inspired them to listen, to speak up, to improve teamwork, to improve the culture, to listen to the patient, that family member, to look at that patient in the bed, listen to that mother.
The DVD continues to be in huge demand here in the United States. It goes on and on and on -- it's been a wonderful, wonderful program. Hospitals make a donation to the foundation. The money comes in from the healthcare industry. It goes back out into the healthcare industry and the forms of these projects and these programs that I'm telling you about. Now, as you see, so far, each of these projects and programs, they are simple, they are basic, they are about communication, they are about teamwork. They are about being patient and family centered.

Another program that I'm really briefly going to run through is the 'Care for the Caregiver Program.' Many years ago, actually about two years after Josie died from medical errors, I realized that patients and family members - we are the first victim, but there's a second victim and the second victim, they are the healthcare providers.
The second victim is that nurse, that doctor, that healthcare provider who was involved in that adverse event and what I learned as I traveled around the country in and out of hospitals, what I learned was that the second victim suffers.
If we can't take care of the second victim, then we will have many other problems on our hands.
I also learned as I traveled around the healthcare industry that there was nothing in place to help the second victim.
The Josie King Foundation created a 'Nurses' Journal' for the second victim.
We started with nurses. It is a wonderful little journal to help nurses deal with the stress, of being involved in an adverse event, really just to deal with the stress of being a nurse.

Another program that's come out of the care for the caregiver concept - it has not really been launched yet. It's going to be launched in January, so stay tuned, I'll keep you posted but it's a program that I'm really excited about is the happiness project. It's going to be a 3-month program for the healthcare industry and for healthcare providers, basically hoping to help healthcare providers become happier and healthier, and I won't go too much into that at the moment, but it's something that we are working on.

One thing I've noticed in the healthcare industry over all of these years and a question I am asked by healthcare providers is how do we keep the momentum going?
How do we keep the energy going on this patient safety front?
How do we encourage this culture of openness, this culture of transparency, here at our hospitals?
How do we encourage our nurses, our doctors, our staff - how do we encourage them to find the near misses, or the good catches?
How do we encourage them to find them, share them, talk about them and learn about them?
What I learned about the healthcare industry here in the United States is the culture still does not exist where healthcare providers feel a 100% comfortable talking about these near misses and these good catches.
A lot of hospitals have do different things.
They offer a Starbucks gift card for the best good catch. Hospital up in Alaska offers a parking place closes to the hospital for a great good catch. Other hospitals have awards for these good catches.
Josie King Foundation decided we wanted to create something really special, something really meaningful for these healthcare providers who are brave enough to find these near misses, which I prefer calling them 'Good Catches' and bring up these good catches and talk about these good catch stories and learn from them.
We created the hero award, the 'Josie King Hero Award.' It's a beautiful piece of artwork.
Hospitals around the country here in the United States, they have monthly recognition, little ceremonies where they award the best good catch to that nurse, that doctor, that respiratory therapist whoever this

really special meaningful Josie King Hero Award because what I've learned over all these years is that sometimes it takes a real hero to do this work.

My book 'Josie's Story' was published a few years ago. I'm so honored and thrilled that it's reached over the Pacific to Japan and has been translated and is therefore everyone in the healthcare industry in Japan to read, to hopefully become inspired by the story. It makes me really happy to know that it is spreading over there.
The year since it has been published, every April I go to my mailbox and in my mailbox, there are big envelopes and these envelopes are from nursing schools, medical schools, and hospitals around the country and the envelopes are filled with reflection letters. They're filled with letters from nursing students, medical students, or folks in hospitals. The reflection letters will say that the book was required reading in these nursing schools, and the assignment after reading the book was to write me a letter on how the book - the story - is affecting these folks as future healthcare providers.
These reflection letters are extremely inspirational and I have stacks and stacks of them. Long story short, from these reflection letters came the revelation and the realization that Josie's Story was being used in medical schools and nursing schools to inspire and to educate.
Josie's Story was being used as an educational tool. We decided at the Josie King Foundation, we would partner with medical educators at Duke University and with their help, we created the 'Josie King Patient Safety Curriculum.' This curriculum was designed by Duke to be flexible. It's a 16-session curriculum. It can be broken down.
Hospitals can use it. Nursing schools can use it. Medical schools can use it. The whole impetus, the whole notion behind the Josie King Patient Safety Curriculum is really simple and its very core essence is that facts provide us with knowledge, stories provide us with wisdom.
That's really what the Josie King Patient Safety Curriculum is all about. It's been a wonderful terrific program to be involved in, its spreading across the country, hopefully maybe one day it will spread to Japan.

I want to take this opportunity again to thank everyone in Japan for listening to me, for letting Josie's Story hopefully seep into your hearts and into your brains.
Hopefully her story will inspire you as it has many healthcare providers here in the United States to continue on your patient journey with new energy to, to remember to speak up, to improve communication, to work together, to listen to that patient, listen to that family member to always be thinking about this whole patient centeredness, which is the sort of the big buzzword here in the United States.
It is my honor to be with you via this video.
I wish I could be there in person. Thank you so much.
Please keep up the great work and many, many thanks.