IHI Expedition

Engaging Frontline Teams to Create a Culture of Safety

Annette Bartley, RN, MS, MPH
Tracy Jacobs, BSN, RN
Today’s Host

Lizzie Grimm, Project Assistant, Institute for Healthcare Improvement
Welcome to today’s session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)
When Chatting...

Please send your message to All Participants
Expedition Director

Tracy Jacobs, BSN, RN, Director, Institute for Healthcare Improvement (IHI), currently directs IHI's work with Improving Patient Care, a wide-reaching improvement program within the Indian Health System, and the ongoing “Achieving Excellence in Primary Care” call series. She has worked on several large IHI collaborative improvement projects, including the Transforming Care at the Bedside inpatient-focused initiative and a ten-year collaborative initiative with the Health Resources and Services Administration's Federally Qualified Health Centers focused on improving chronic disease and preventive care services for the nation's underserved populations. Ms. Jacobs has 12 years of experience in health care quality improvement.
Today’s Agenda

- Review activities from the past two weeks (Action Period)
- New Content: Tools and techniques for frontline staff
- Homework for next session
Our Intent – Overall Program Aim

- Understand the discipline of patient safety and its role in minimizing the incidence and impact of adverse events, and maximizing recovery from them
- Create a culture of safety amongst frontline healthcare teams that protects all
- Active participants/homework assignments
- Applying the theory in practice
- Sharing the learning
Expedition Objectives

At the end of the Expedition each participant will be able to:

- Describe background and context of patient safety
- Identify tools which will help to improve communication and teamwork, essential to building culture
- Apply a range of simple tools and improvement methods for engaging staff in improving patient safety and measuring improvement
- Identify strategies for managing conflict management, including: appropriate assertion and critical language
- Describe strategies for involving patients and family members in preventing harm
Schedule of Calls

Session 5 – Tools and Techniques for the Frontline Staff
Date: Thursday, April 25, 1:00 PM – 2:00 PM ET

Session 6 – Engaging Patients and Families in Preventing Harm
Date: Thursday, May 9, 1:00 PM – 2:00 PM ET
Annette J. Bartley RGN, BA (Hon) MSc, MPH, Programme Director, The Health Foundation’s Safer Patient Network, UK, is a registered nurse with over 30 years of health care experience. In 2006 she was awarded a one-year Health Foundation Quality Improvement Fellowship at the Institute for Healthcare Improvement, during which time she also completed an MPH at Harvard University. Ms. Bartley was faculty lead for the Welsh pilot of Transforming Care at the Bedside (TCAB) and now advises the Welsh Assembly Government as TCAB spreads across Wales. She is a founding member of the Welsh Faculty for Healthcare Improvement and serves as faculty for the IHI TCAB Collaborative, the Wales 1,000 Lives plus Transforming Care programme, the South West Quality and Patient Safety Improvement programme, the National Tissue Viability pressure ulcer prevention pilot programme for Quality Improvement Scotland, and the Kings Fund hospital pathways programme.
Action Period Work

Understand where harm lies in your unit

- Review the last five harm events on your unit
  - What happened? What surprised you? What will you do differently as a result?

- Use Safety Cross to measure specific harm e.g., falls with harm, pressure ulcers, catheter associated infections
  - Report progress at safety briefing/handover

- If an adverse event occurs use the See it, Swarm it, Solve it approach to act in real time

Tools and Techniques for the Frontline Staff
Session Objectives

By the end of this session participants will be able to:

• Understand the principles which underpin quality improvement and patient safety

• List some of the key success factors which will enable frontline teams to reduce harm and keep patients safe

• Describe a range of different tools and techniques which can be used to prevent harm and improve quality
Underpinning Principles

- Transformational leadership and culture
- Teamwork and vitality
- Understanding of safety principles and reliability
- Focus on patient and what matters most to them rather than intervention
- Value-added care
How Do Great Leaders Inspire Action?

Simon Sinek

http://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action.html
The Characteristics of an Effective Leader…

- Inspiring
- Has a vision
- Integrity & diplomacy
- Motivational
- Communication & listening skills
- Coaching skills
- Decisive
The Quality Leadership Triangle

The Institute for Healthcare Improvement
“Organisational cultures are created by leaders, and one of the most decisive functions of leadership might well be the creation, the management, and if and when it becomes necessary, the destruction of culture. Culture and Leadership when one examines them closely are two sides of the same coin and neither can really be understood by itself”
A Framework for Improvement

- Generate the will
- Set clear local aims
- Develop your driver diagram
- Create a measurement plan
- Get into action plans - what will you DO?
- Encourage innovative thinking
Understand the Culture and Context

- What’s good about it?
- What’s not so good?
- What could be improved?
Maintaining the Focus on Patients

- **Relational**
  - Warm but chaotic
  - Everything works
  - Unpleasant and inefficient
    - “Cold comfort farm”
  - Efficient but impersonal
    - Coordinated, integrated
    - Warm, fed, watered
    - “Battery chicks?”

- **Transactional**

**The Kings Fund**
Prepare the Ground

\[ S + P = 0 \]

- **S=Structure**: The environment in which health care is provided
- **P=Process**: The method by which health care is provided
- **O=Outcome**: The consequence of the health care provided

*Avedis Donabedian Physician*
Getting It Right – First, Do No Harm!

- Fundamental Safety Principles
  - Prevention
  - Detection
  - Mitigation
Key Ingredients for Improvement

A Clear Aim - Measurement - Action
In Amsterdam, the tile under Schiphol’s urinals would pass inspection in an operating room. But nobody notices. What everybody does notice is that each urinal has a fly in it.

Look harder, and the fly turns into the black outline of a fly, etched into the porcelain. It improves the aim. If a man sees a fly, he aims at it. Fly-in-urinal research found that etchings reduce spillage by 80%. It gives a guy something to think about. That’s the perfect example of process control.
**Definition**: A driver diagram is used to conceptualize an issue and determine its system components which will then create a pathway to get to the goal.

- **Primary drivers** are system components which will contribute to moving the primary outcome.
- **Secondary drivers** are elements of the associated primary driver. They can be used to create projects or change packages that will affect the primary driver.
Making the Connections

Risk Identification

Risk Assessment

Communication of Risk status

Appropriate preventative strategy implemented

Evaluation of outcome
"Reliability Occurs by Design Not by Accident"
“Reliability occurs by design not by accident”

This is a story about 4 people named everybody, somebody, anybody and nobody. There was an important job to be done and Everybody was asked to do it. Everybody was sure somebody would do it. Anybody could have done it but nobody did it. Somebody got angry about that because it was Everybody's job. Everybody thought anybody could do it, but nobody realized that everybody wouldn't do it. It ends up that everybody blames somebody when nobody did what anybody could have done
Reduce Variation

**Current** - Variable, lots of autonomy not owned, poor if any feedback for improvement, constantly altered by individual changes, performance stable at low levels

**Desired** - variation based on clinical criteria, no individual autonomy to change the process, process owned from start to finish, can learn from defects before harm occurs, constantly improved by collective wisdom - variation
What is a High Reliability Organization (HRO)?

An organization:
- Conducting relatively error free operations
- Over a long period of time
- Making consistently good decisions resulting in high quality and reliable operations
A HRO Must Sustain a “Mindful Infrastructure”

Attributes of High Reliability Organizations
1. Preoccupation with failure
2. Reluctance to simplify interpretations
3. Sensitivity to operations
4. Commitment to resilience
5. Deference to expertise

Weick, Managing the Unexpected: Assuring High Performance in an Age of Complexity, Jossey Bass 2001
Attributes of High Reliability Organisations

1. Preoccupation with failure
   - Small failures are as important as large failures
     - Example: wrong date, name lack of signature
   - Worry about normalization of unexpected events
   - Avoid complacency:
     - Success breeds complacency
     - Success narrows perceptions
Attributes of High Reliability Organisations

2. Reluctance to simplify interpretations
   - Pay closer attention to context
   - Look for the root cause, not the obvious cause
Attributes of High Reliability Organizations

3. Sensitivity to operations – “situational awareness”

- Attentive to the front line where the real work gets done
- Authority moves toward expertise
- Use resources so people can see and comprehend what is happening dashboards
- Allow continuous adjustments that prevent errors from accumulating
Reducing Avoidable Harm Locally

Days since last... ___ days
The Lens of Profound Knowledge

Aims or values

- Appreciation of a system
- Theory of Knowledge
- Psychology
- Understanding Variation
Developing a change
Testing a change - cycle 1, cycle 2, cycle 3
Implementing a Change
Degree of belief that a change will result in improvement
LOW
MODERATE
HIGH
Change needs further testing
Unsuccessful change!
Successful change!

Small scale, local scope
Organization-wide scope & scale
Revised Use of the PDSA Cycle

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Hunches, Theories, Ideas

Changes That Result in Improvement

Very Small Scale Test

Follow-up Tests

Wide-Scale Tests of Change

DATA

Hunches
Theories
Ideas

What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Adopter Categories

Different adopter types require different messages and strategies of communication.
Adoption Is a SOCIAL thing!

A better idea... communicated through a social network... over time

Richard Scoville, IHI
Attributes of High Reliability Organizations

3. Sensitivity to operations – “situational awareness”

- Attentive to the front line where the real work gets done
- Authority moves toward expertise
- Use resources so people can see and comprehend what is happening dashboards
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Attributes of High Reliability Organisations

4. Commitment to resilience

- Anticipate trouble spots
- A focus on intelligent reaction, improvisation
- Develop capabilities to *detect*, contain, and ‘bounce back’ from inevitable error
  - Improve capacity to do quick studies (small tests/PDSA’S)
- Develop swift trust
- Engage in just-in-time learning
Attributes of High Reliability Organisations

5. Deference to expertise

- Decisions are made on the front line, and authority migrates to the people with the most expertise, regardless of their rank.
- Avoidance of the structure of deference to the powerful, coercive, or senior…
Mindfulness: Weick and Sutcliffe

To be mindful is to have an enhanced ability to discover and correct errors that could escalate into a crisis.”

“Together these five processes produce a collective state of mindfulness.”
IDEO – “The Deep Dive” *™

IDEO has been identified as America’s Leading Design Firm.

IDEO’s special ingredients:
- Teams
- Culture
- Methodology

Deloitte Consulting Limited *™
Simple Tools

- Real time root cause analysis - See it, Swarm it, Solve it!
- Real time feedback of data
- Safety Cross/Safety briefings/huddles
- Ask 5/Take 5/ Five Why’s?
- Feedback the incident and resultant action to staff on handover/safety briefing
The “Snorkel”*

- Clarity of Aim
- Understand the context….
- Propose a Design Challenge
- How might we….?
- Storytelling
- Ideas storming
- Select top ideas (multi-vote)
- Prioritize ideas for development
- Plan prototypes/enactments
- Design first series of PDSA tests
- Innovate

*Transforming Care at the bedside

Robert Wood Johnson Foundation & Institute for Health care Improvement
How might we fully engage service users and their family members in preventing harm?
Focus and Simplicity

“That’s been one of my mantras — focus and simplicity. Simple can be harder than complex: You have to work hard to get your thinking clean to make it simple. But it’s worth it in the end because once you get there, you can move mountains.”

— Steve Jobs
The Pursuit of Happiness

- Team
- Resilience
- Joy
‘If you want to build a ship do not gather men together and assign tasks. Instead teach them the longing for the wide endless sea’ (Saint Exupery, Little Prince)
Action Period

- Identify three things you will take away from the expedition
- As an individual, reflect on what YOU will do differently as a result of this investment?
- What will you and your team/organization do differently?
- Plan and do at least one small test of change
Questions?

Raise your hand

Use the Chat
Volunteers?
Progress Summary

- Content and background to patient safety
- Essentials of teamwork
- Effective communication
- Measurement of adverse events
- Tools and techniques for the frontline staff
- Engaging patients and families in preventing harm
Expedition Communications

- Listserv for session communications: SafetyExpedition@ls.ihi.org
- To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes
Final Session

Session 6 – Engaging Patients and Families in Preventing Harm

Date: Thursday, May 9, 1:00 PM – 2:00 PM ET