Managing Change and Culture to Improve Safety

Heartland Health Alliance QI Task Force
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Objectives

1. Describe the key elements of a culture of safety
2. Apply processes of organizational and individual change to explain challenges and opportunities with buy-in
3. Examine the post-fall huddle as an intervention to improve patient safety and change culture and develop a well-formulated plan for its implementation
Objective 1: What is safety culture?

- Culture defined
- Role of Organizational Culture
- 3 Levels of Culture
- 4 Components of Safety Culture
Culture Defined

• LEARNED,¹ shared, enduring, beliefs and behaviors that reflect an organization’s 
  willingness to learn from errors²

• Four beliefs present in a safe, informed culture³
  – Our processes are designed to prevent failure
  – We are committed to detect and learn from error
  – We have a just culture that disciplines based on risk taking
  – People who work in teams make fewer errors
The Role of Organizational Culture

Organizational Culture

• Allows us to make sense of environment
• Reflects common language… is heard and observed
• Leaders create/teach culture
  - Share information
  - Reward, provide feedback
  - Hold people accountable

Safety Culture

• A cross cutting contextual factor
• Moderates effectiveness of patient safety interventions
• Associated with adverse events and patient satisfaction
Three Levels of Organizational Culture\(^1\)

“…values reflect *desired* behavior but are not reflected in *observed* behavior.” (Schein, 2010, pp. 24, 27)

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Beliefs &amp; Values</th>
<th>Underlying Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desired Behavior: Managers hold staff accountable for behavioral choices</td>
<td>Values: • Shared accountability • Teamwork</td>
<td>Assumption: Safety is a system property</td>
</tr>
<tr>
<td>Observed Behavior: Managers respond to events based on severity of outcome</td>
<td>Values: Autonomy</td>
<td>Assumption: Safety is a result of individual competency</td>
</tr>
</tbody>
</table>

Four Components of Safety Culture

1. Reporting Culture
2. Just Culture
3. Flexible (Teamwork) Culture
4. Learning Culture

- Effective reporting and just cultures create atmosphere of trust
- Sensemaking of patient safety events and high reliability result from an explicit plan to engineer behaviors from each component of safety culture
<table>
<thead>
<tr>
<th>Reason’s Components&lt;sup&gt;5&lt;/sup&gt;</th>
<th>HSOPS Dimension or Outcome Measure</th>
</tr>
</thead>
</table>
| **Reporting Culture** - a safe organization is dependent on the willingness of front-line workers to report their errors and near-misses | • Frequency of Events Reported (U)  
• Number of Events Reported (O, H) |
| **Just Culture** - management supports and rewards reporting; balances system and individual accountability | • Nonpunitive Response to Error (U)  
• Just Culture Assessment (U, pilot questions for HSOSPS 2.0) |

O = Outcome measure  
U = Measured at level of unit/department  
H = Measured at level of hospital
<table>
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<th>Reason’s Components(^5)</th>
<th>HSOPS Dimension or Outcome Measure</th>
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</table>
| **Flexible Culture** - authority patterns relax when safety information is exchanged because those with authority respect the knowledge of front-line workers | • Teamwork w/in Units (U)  
• Staffing (U)  
• Communication Openness (U)  
• Teamwork across Units (H)  
• Hospital Handoffs (H) |
| **Learning Culture** - organization will analyze reported information and then implement appropriate change | • Hospital Mgt Support (H)  
• Manager Actions (U)  
• Feedback & Communication (U)  
• Organizational Learning (U)  
• Overall Perceptions of Safety (O)  
• Patient Safety Grade (O, U) |
Improving safety culture increases likelihood of success of all other quality improvement and patient safety interventions.
Objective 2: Change processes and change management

- The change problem
- Change for the organization
- Change for the individual
- From knowledge to behavior and results
50 Reasons Not To Change

- I'm not sure my boss would like it.
- It's too expensive.
- We'll catch flak for that.
- That's someone else's responsibility.
- It won't fly.
- We've always done it this way.
- It's too political.
- We're doing OK as it is.
- We don't have the staff.
- We tried that before.
- It's just a fad.
- Maybe, maybe not.
- We've never done that before.
- It's too ambitious.
- No one asked me.
- No es mi problema.
- It's too complicated.
- It can't be done.
- It's against tradition.
- There's not enough time.
- There's no clear mandate.
- It needs more thought.
- Another department tried that.
- It's too entrenched.
- They're too lazy.
- There's too much red tape.
- It's not my job.
- It's not for me?
- It needs more thought.
- We have too many layers.
- We have to budget for it.
- It will take too long.
- We didn't have the equipment.
- We don't have the authority.
- It's impossible.
- We can't take the chance.
- It's hopeless.
- They won't fund it.
- It's too radical.
- There's too much red tape.
- It won't fly.
- We're waiting for guidance on that.
- It won't work in this department.
- It will never fly upstairs.
- It needs a clear mandate.
- They don't really want to change.
- I'm all for it, but...
- Me falta ánimo.
- ¡Nunca pasará!
Rogers’ Organization Innovation Process

**INITIATION**
- **Agenda Setting/Need**
  - Identify need for innovation (diagnose performance gap)
- **Matching**
  - Design innovation to address need and bridge gap
- **Redefining**
  - Re-invent innovation to match context, restructure organization to fit innovation
- **Clarifying**
  - Make roles and tasks associated with innovation clear
- **Routinizing**
  - Hard-wire: audits, policies, procedures, job descriptions, performance appraisals

**DECISION**
- Plan
- Do
- Study
- Act

**IMPLEMENTATION**
Rogers’ Individual Innovation Process

Knowledge
- Awareness — it exists
- How-to
- Principles — how it works

Persuasion
- Relative advantage
- Compatibility
- Complexity
- Trialability
- Observability

Decision
- Adopt
- Reject

Implementation
- Re-invention: Modification to fit an existing environment

Confirmation
- Recognize benefits
- Make it routine
- Promote it to others

(Rogers, 2003; pp. 169, 421)
Kirkpatrick’s Taxonomy of Training Criteria\textsuperscript{8,9} (Kirkpatrick & Kirkpatrick, 2006; Grossman & Salas, 2011)

Transfer Problem: much of training does not result in behavior change in the work environment.

Transfer
(new knowledge transferred to behavior in the work environment)

Learning
(immediate and retained changes in knowledge, demonstration of skill)

Reaction
(satisfaction and utility judgment)

Results
(impact)

Reliable change
Role modeling Opportunities to practice
Motivated learners “I will use this training…”

People who …

Don’t know
Know
Do
How do Rogers’ Frameworks and/or Kirkpatrick’s Taxonomy help explain why a recent change effort was/was not successful?
Objective 3: Tools to improve safety and culture – The case for post-fall huddle implementation

• The post-fall huddle
• Evidence-based outcomes
• Plan for implementation
Why a Post-Fall Huddle?

- Root cause of fall
- Decrease patient’s future fall risk
- Improve bedside teamwork
- Improve coordination across system
- Apply lessons learned at system level
How is it done?

**CAPTURE FALLS: POST-FALL HUDDLE GUIDE**

1. Establish facts…a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient’s plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?
8. Complete documentation
   a. Who attended
   b. Type of fall
   c. Type of error

**POST-FALL HUDDLE FACILITATOR TIPS**

1. Create a safe, learning-focused environment (e.g., this is an opportunity for the front line to learn about why a patient fell – actively listen and be slow to judge)
2. Ask probing questions (e.g., ask “why?” until root causes are identified)
3. Encourage open and honest sharing of information from all huddle participants (e.g., encourage turn taking and recognize each person’s contribution)
4. Give praise and acknowledge good work (e.g., say “thank you” and “nice job” when appropriate)
5. Identify mistakes made and focus on how staff can improve in the future (e.g., acknowledge the mistake but specifically mention an action staff can take to address this issue in the future)

https://www.youtube.com/watch?v=ZIqAmNEL6Q4&feature=youtu.be
From bedside discussion...

Post-Fall Huddle Facilitation Guide

Purpose: To lead frontline staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

Remember: Patients fall because their center of mass is outside their base of support.

During the huddle look for specific answers and continue asking "why?" until the root cause is identified.

1. Establish facts:
   1a. Did we know this patient was at risk? ______ YES ______ NO
   1b. Has this patient fallen previously during this stay? ______ YES ______ NO
   1c. Is this patient at high risk of injury from a fall? (AKS)
   - Age 85+
   - Brittle Bones
   - Cogulation
   - Surgical Post-Op Patient

2. Establish what patient and staff were doing and why.

ASK: What was the patient doing when he/she fell? (Be specific: e.g. transferring sit—stand from bedside chair without his walker). Ask why multiple times.

ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.

3. Determine underlying root causes of the fall.

ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.

4. Make changes to decrease the risk that this patient will fall or be injured again.

ASK: How could we have prevented this fall?
- Need to consult with physical/occupational therapy about mobility/positioning/standing
- Need to consult with pharmacy about medications

ASK: What changes will we make in this patient’s plan of care to decrease the risk of future falls?

Ask: What patient or system problems need to be communicated to other departments, units or disciplines?

Post-Fall Huddle Documentation

Directions: Items 1 - 3 should be completed by the huddle facilitator. Item 4 should be completed by the fall risk reduction team.

1. Date of Huddle__________ Time of Huddle__________ Huddle Facilitator Initials__________

2. Who was included in the huddle? CHECK ALL THAT APPLY
   - Patient
   - Primary Nurse
   - COTA
   - Physical Therapist
   - Family/Carer
   - OB
   - Physical Therapy Assistant
   - Charge Nurse
   - Occupational Therapist
   - Pharmacy Tech
   - Quality Improvement Coordinator
   - Other:

3. Please identify the proximal cause(s) of the fall by checking ALL appropriate boxes below and describe actions taken to prevent a reoccurrence for this patient.

<table>
<thead>
<tr>
<th>FALL CAUSE</th>
<th>FALL TYPE</th>
<th>ACTIONS TAKEN TO PREVENT REOCURRENCE FOR THIS PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental (Extrinsic) Risk Factors</td>
<td>Accidental</td>
<td>Possibly could have been prevented</td>
</tr>
<tr>
<td>Examples: Liquid on floor, Trip over tubing, equipment, or furniture, Equipment malfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known Patient-Related (Intrinsic) Risk Factors</td>
<td>Anticipated Physiological</td>
<td>Possibly could have been prevented</td>
</tr>
<tr>
<td>Examples: Confusion/Agetiation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Poor hydration, Centrally acting medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown, Unpredictable Sudden Condition</td>
<td>Unanticipated Physiological</td>
<td>Unpreventable</td>
</tr>
<tr>
<td>Examples: Heart Attack, Seizure, Drop attack</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. If preventable, determine error type and describe actions taken to decrease risk of reoccurrence at the system level.

ERROR TYPE | ACTIONS TAKEN TO DECREASE RISK OF REOCURRENCE AT THE SYSTEM LEVEL |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Task</td>
<td>An individual did NOT ensure planned interventions were in place as intended (e.g. bed alarm not activated)</td>
</tr>
<tr>
<td>Judgment</td>
<td>An individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting in the absence of a policy not to do so)</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Communication among multiple staff members was Incomplete, Inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)</td>
</tr>
<tr>
<td>System</td>
<td>Communication and multiple elements (tasks, knowledge, equipment) combine to make the system unreliable (e.g. unreliable process for managing orthostatic BP across the system)</td>
</tr>
</tbody>
</table>

Thank you for contributing to patient safety and quality of care.
Facilitator: Please return this completed form to your quality improvement coordinator.
Quality Improvement Coordinator, please scan and email via encryption to gquan@unmc.edu.

Quality Improvement: Not part of the medical record. Not discoverable by Nebraska Rev. Stat. Section 71-701 to 71-713.
Association Between Post-Fall Huddles and Repeat Falls per Patient (n=16 Hospitals)

\[ r = -0.734, p = 0.001 \]
### Post-Fall Huddle Participation and Perceptions of Safety Culture (n=570-589 individuals)

<table>
<thead>
<tr>
<th>Category</th>
<th>Participated in a Post-fall Huddle</th>
<th>Did Not Participate in a Post-fall Huddle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Learning</td>
<td>82%</td>
<td>79%</td>
</tr>
<tr>
<td>Nonpunitive Response to Error</td>
<td>83%</td>
<td>74%</td>
</tr>
<tr>
<td>Teamwork Across Hospital Departments</td>
<td>70%</td>
<td>63%</td>
</tr>
<tr>
<td>Hospital Handoffs &amp; Transitions</td>
<td>76%</td>
<td>67%</td>
</tr>
</tbody>
</table>

#### Mistakes have led to positive changes here
- We make changes to improve patient safety, we evaluate their effectiveness
- Staff feel like their mistakes are held against them
- When an event is reported, it feels like the person is being written up, not the problem
- There is good cooperation among hospital departments that need to work together
- Hospital departments work well together to provide the best care for patients
- Hospital departments do not coordinate well with each other
- It is often unpleasant to work with staff from other hospital departments
- Things “fall between the cracks” when transferring patients from one department to another
- Important patient care information is often lost during shift changes
- Problems often occur in the exchange of information across hospital departments

### Post-Fall Huddle Participation and Perceptions of Teamwork Support For Fall Risk Reduction

<table>
<thead>
<tr>
<th>Category</th>
<th>Participated in a Post-fall Huddle</th>
<th>Did Not Participate in a Post-fall Huddle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Structure</td>
<td>95%</td>
<td>89%</td>
</tr>
<tr>
<td>My unit/department share information that enables timely decision making about fall risk reduction by the direct patient care team.</td>
<td>93%</td>
<td>86%</td>
</tr>
<tr>
<td>My unit/department has clearly articulated goals for fall risk reduction.</td>
<td>93%</td>
<td>86%</td>
</tr>
<tr>
<td>My supervisor/manager considers staff input when making decisions about fall risk reduction.</td>
<td>91%</td>
<td>78%</td>
</tr>
<tr>
<td>My supervisor/manager provides opportunities to discuss the unit/department’s performance after a patient fall.</td>
<td>88%</td>
<td>74%</td>
</tr>
<tr>
<td>My supervisor/manager takes time to meet with staff to discuss the fall risk reduction program.</td>
<td>87%</td>
<td>81%</td>
</tr>
<tr>
<td>My supervisor/manager successfully resolves conflicts involving the fall risk reduction program.</td>
<td>92%</td>
<td>87%</td>
</tr>
</tbody>
</table>

#### Team Leadership
- My supervisor/manager models appropriate team behavior in support of the fall risk reduction program.
- My supervisor/manager ensures that staff are aware of any situations or changes that may affect the fall risk reduction program.
- My supervisor/manager reevaluates a patient’s fall risk reduction plan of care when aspects of the situation have changed.

#### Situation Monitoring
- Staff meet to reevaluate a patient’s fall risk reduction plan of care when aspects of the situation have changed.
Post-Fall Huddle Implementation

How do Rogers’ Frameworks and Kirkpatrick’s Taxonomy help us plan for the implementation of post-fall huddles as a patient safety intervention?

Organizational Change Effort

- **Initiation**
  - Agenda Setting/Need
- **Decision**
  - Matching
- **Implementation**
  - Redefining
  - Clarifying
  - Routinizing

<table>
<thead>
<tr>
<th>Transition from Learning to Behavior and Results</th>
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<tr>
<td><strong>Results</strong> (impact)</td>
</tr>
<tr>
<td><strong>Transfer</strong> (new knowledge transferred to behavior in the work environment)</td>
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<td><strong>Learning</strong> (immediate and retained changes in knowledge, demonstration of skill)</td>
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**Organizational Change Effort**

- Identify need for innovation (diagnose performance gap)
- Design innovation to address need and bridge gap
- Re-invent innovation to match context, restructure organization to fit innovation
- Make roles and tasks associated with innovation clear
- Hard-wire: audits, policies, procedures, job descriptions, performance appraisals

**Individual Change Effort**

- Knowledge
- Persuasion
- Decision
- Implementation
- Confirmation

- Awareness — it exists
- How-to Principles — how it works
- Relative advantage
- Compatibility
- Complexity
- Trialability
- Observability
- Adopt
- Reject
- Re-invention: Modification to fit an existing environment
- Recognize benefits
- Make it routine
- Promote it to others
What do we learn from?
Post-incident learning

What *can* we learn from?
Learning from success
CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

http://unmc.edu/patient-safety/capture_falls.htm
References

1. Schein, E.H. Organizational Leadership and Culture 4\textsuperscript{th} ed. San Francisco: John Wiley & Sons; 2010.