Managing Culture Change
Webinar 2 to complete requirements for Master Trainer Certification

November 21, 2013

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University of Nebraska Medical Center
Supported By

Nebraska Department of Health and Human Services

Nebraska Coalition for Patient Safety
1. Teach essential team skills using the TeamSTEPPS curriculum

2. Develop an Action Plan to implement TeamSTEPPS

3. Use a strategy to manage culture change
Managing Culture Change

Objectives

1. Explain the concept of safety culture (what are you trying to change?)
2. Use an explicit strategy to improve safety culture using team skills
3. Explain the impact of a team training program on hospital safety culture using Kirkpatrick’s Taxonomy of Training Criteria
Closing the Loop from Webinar 1

- Nonclinical and support staff examples
- Need to conduct patient safety culture survey
  - Contact us; we will conduct survey Q1 2014
- Share what others have done
  - Monthly Calls
  - Resources on web site
- TeamSTEPPS already in place…. action plan? Yes, targeted implementation to improve use of one tool in your unit or hospital
• Evidence base for effectiveness and return on investment is continually expanding...
• We distribute evidence from the literature with monthly call reminders (reference #9)

There is evidence that successful team training and effective teamwork improve patient outcomes\(^1-^9\) and safety culture.\(^10,^11\)

Reference numbers refer to the listing on the next two slides
Recent Evidence


Resources on Web Site

• TeamSTEPPS Training
  
  http://www.unmc.edu/patient-safety/teamstepps_training.htm
  – Recordings of Webinars
  – Slides posted from Modules 1 Intro, 2 Team Structure, 7 Summary under TeamSTEPPS Training
  – Clarification for items frequently missed on knowledge test

• TeamSTEPPS Toolkit
  
  http://www.unmc.edu/patient-safety/teamstepps_toolkit.htm
  – Tools to implement TeamSTEPPS
  – Structured communication tools
Recap of Action Planning

Shift Towards a Culture of Safety

ACTION PLAN (See Webinar 1)
1. Define the problem
2. Create a change team
3. Define aim...targeted or transformational
4. Define TeamSTEPPS tools to use
5. Decide effectiveness measures
6. Develop implementation plan
7. Develop sustainment plan
8. Develop communication plan
9. Put it all together
10. Review plan with all stakeholders
What should be the aim of your facility's initial TeamSTEPPS implementation?

- Targeted and unit-based; pilot test the implementation of all TeamSTEPPS tools in one unit. (33.3%)
- Targeted and tool-based; implement one tool (i.e. SBAR, CUS, Briefs/Huddles/Debriefs) across the whole facility. (66.7%)
- Transformational; train the whole hospital in the use of all tools. (Preferred by those hospitals new to TeamSTEPPS)

Preferred by those hospitals new to TeamSTEPPS
Tool-Based Targeted Implementation

Preferred by those hospitals previously trained

What is the best strategy for your facility to improve dissemination and sustainment of team skills across your facility?

- Targeted and unit-based; retrain one specific unit in the use of all TeamSTEPPS tools.
- Targeted and tool-based; focus on reinforcing the use of one tool (i.e. SBAR, CUS, Briefs/Huddles/Debriefs) across the whole facility.
- Transformational; retrain the whole hospital in the use of all tools.

- Targeted and unit-based: 12.0%
- Targeted and tool-based: 32.0%
- Transformational: 56.0%
Recap of Action Planning

Shift Towards a Culture of Safety

**PHASE I**
Assessment

- Pre-Training Assessment
  - SITE ASSESSMENT
  - CULTURE SURVEY
  - DATA/MESURES

**PHASE II**
Planning, Training, & Implementation

- Training
- Intervention
- Test

**PHASE III**
Sustainment

- Culture Change
  - COACH & INTEGRATE
  - MONITOR THE PLAN
  - CONTINUOUS IMPROVEMENT

Set the Stage ★ Decide What to Do ★ Make it Happen ★ Make it Stick
Explain the concept of safety culture

• Definition
• 3 Levels of Culture
• 4 Components of Culture
• Role of Organizational Culture
• Safety culture is associated with adverse events and patient satisfaction
What is a Safety Culture?

• LEARNED,\textsuperscript{1} enduring, shared, beliefs and behaviors that reflect an organization’s \textit{willingness to learn from errors}\textsuperscript{2}

• Patient safety has a high relative importance to other organizational goals (i.e. productivity)\textsuperscript{3}
<table>
<thead>
<tr>
<th>Beliefs</th>
<th>Dimension and Item from HSOPS</th>
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</thead>
<tbody>
<tr>
<td>Our processes are designed to prevent failure.</td>
<td><strong>Overall Perceptions of Safety</strong>: Our procedures and systems are good at preventing errors from happening.</td>
</tr>
<tr>
<td>We are committed to detect and learn from error.</td>
<td><strong>Frequency of Events Reported</strong>: When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported? <strong>Organizational Learning</strong>: Mistakes have led to positive changes here. <strong>Feedback and Communication about Error</strong>: We are given feedback about changes put into place based on event reports.</td>
</tr>
<tr>
<td>We have a just culture that disciplines based on risk taking.</td>
<td><strong>Nonpunitive Response to Error</strong>: Staff worry that mistakes they make are kept in their personnel file.</td>
</tr>
<tr>
<td>People who work in teams make fewer errors.</td>
<td><strong>Teamwork within Depts</strong>: When a lot of work needs to be done quickly, we work together as a team to get the work done. <strong>Communication Openness</strong>: Staff feel free to question the decisions or actions of those with more authority.</td>
</tr>
</tbody>
</table>
“...values reflect desired behavior but are not reflected in observed behavior.” (Schein, 2010, pp. 24, 27)
<table>
<thead>
<tr>
<th>Reason’s Components⁵</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 will support and reward reporting; discipline occurs based on risk-taking | • Nonpunitive Response to Error (U) |

O = Outcome measure  
U = Measured at level of unit/department  
H = Measured at level of hospital
<table>
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<tr>
<th>Reason’s Components(^5)</th>
<th>HSOPS Dimension or Outcome Measure</th>
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| **Flexible Culture** - authority patterns relax when safety information is exchanged because those with authority respect the knowledge of frontline workers | • Teamwork w/in Units (U)  
• Staffing (U)  
• Communication Openness (U)  
• Teamwork ax 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 (U)  
• Patient Safety Grade (O, U) |
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
Organizational Culture\textsuperscript{1}

- 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\textsuperscript{7}

- A cross cutting contextual factor
- Moderates effectiveness of patient safety interventions
- Associated with adverse events and patient satisfaction
Higher HSOPS scores are associated with fewer adverse events, which validates patient safety culture assessment as a meaningful indication of the safety of patients.

FIGURE 1. Scatter plot of PSI composite versus HSOPS composite average (N = 179).
HSOPS and Patient Satisfaction

“...behaviors and attitudes [of hospital employees] can directly affect the pain, discomfort, health, and recovery of patients.”
Improving safety culture increases likelihood of success of all other patient safety interventions.
Why Does Change Fail?

• Why isn’t the US on the metric system?

• Examples from your organization

http://static.ddmcdn.com/gif/us-metric-system-1.jpg
Multiple Strategies for Change

• Kotter’s Eight Steps of Change\textsuperscript{10}
• Comprehensive Unit Based Safety Program\textsuperscript{11}
• Diffusions of Innovation\textsuperscript{12}
Create a Sense of Urgency

• Get people’s attention (with data and stories)!
  – HSOPS results, Harmful events including fall Rates, Patient satisfaction, Core Measures

• Sell the need for change...
  and the consequences of not changing to the board, senior leaders, department managers, providers

• Immerse front line staff in information about the change (bulletin boards, contests)

• Discuss ways to empower people to solve problems associated with the change
• Choose **proven leaders** who can drive the change process
  – Formal power with high credibility
  – Informal opinion leaders
  – Interprofessional
  – Set expectations for follow through

• Need management and leadership skills
  – Management skills control the process and details
  – Leadership skills drive the change with a vision

...TeamSTEPPS initiative should have a designated executive sponsor
• Work with senior leaders to define and communicate your vision for change...
  – Use structured communication at shift change to decrease errors
  – Ensure all employees feel psychologically safe to speak up and advocate for patients
  – Improve management of changing workloads to decrease overtime and turnover
  – Move to a new ice berg!

• Share how this change is consistent with mission and core values

Our vision: A nomad colony...free with no fixed home.
This is education and training

• Encourage discussion, dissent, disagreement, debate ... keep people talking

• Tell people what you know—and what you don’t know

• Value resisters (NO NO)
  – They clarify the problem and identify other problems that need to be solved first
  – Their tough questions can strengthen and improve the change
  – They may be right—it is a dumb idea!

Communicate for Understanding & Buy-In

communicate, communicate, communicate...
It is important to improve teamwork in our organization because:

- 1/4 of our nursing staff believe that shift changes are problematic for patients
- 2/3 of our clinical staff do not have the skills to speak up to feel psychologically safe speaking up to those with more authority when patient safety is at stake
- Only ½ of the staff in the ED agree that there is good cooperation among hospital departments that need to work together.
- RCA identified poor communication during a handoff of a patient from floor to radiology that led to a fall
TeamSTEPPS stands for: *Team Strategies and Tools to Enhance Performance and Patient Safety*

*It is an evidence-based team training system that consists of four categories of skills...*

1. **Leadership**—conduct briefs, huddles, and debriefs
2. **Situation Monitoring**—individuals watch each others’ backs (cross monitor) so all have a shared mental model
3. **Mutual Support**—back-up behaviors that allow team members to become self-correcting
4. **Communication**—standardized information exchange strategies such as SBAR, check-back, call-out, handoff, and checklists
Empower Others to Act\textsuperscript{10}

- Train employees so they have the desired skills and attitudes
- Identify personnel with the vision and skills to COACH others
- Manage high-level resisters...how did professor manage No NO?

http://www.kotterinternational.com/our-principles/our-iceberg-is-melting

An organization cannot be improved from the top only
Produce Short-Term Wins

• Provide positive feedback (shirts, pins)
  – Further builds morale and motivation
  – Results from debriefs

• Provide feedback to plan next goal

• Create greater difficulty for resisters to block further change

• Provide leadership with evidence of success
Don’t Let Up

• Evaluate your training sessions and learn from the evaluations (form available on website)
• Reaffirm the vision
• Celebrate successes and accomplishments
• Orient new employees to the tools
• Include in annual training to reinforce behaviors
• Tool of the month
Create a New Culture

- Hard wire the change
  - Job descriptions
  - Performance evaluations
  - Policies/procedures
- Use language and tools in clinical and nonclinical settings
  - Call for briefs, huddles, and debriefs
  - Monitor the situation to establish situation awareness
  - Seek and offer task assistance
  - Structure communication with SBAR, Call-out, Check-back and I PASS the BATON
  - SBAR can structure email communication, document reviews, requests for maintenance
An idea or practice that is perceived as new

Diffusion process: *Innovation* is *communicated* through *channels over time* among members of a *social system*\(^{12}\)
Getting a new idea adopted, even when it has obvious advantages, is difficult. Many innovations require a lengthy period of many years from the time when they become available to the time when they are widely adopted. \(^\text{12}\)

Attributes of Innovations

General Attributes
• Relative advantage
• Compatibility
• Complexity
• Trialability
• Observability

TeamSTEPPS
• Train-the-Trainer
• Fundamentals
• Essentials
• Coaching
• Culture Assessment
• Implementation/Action Planning

Characteristics of Organizations/Individuals

Innovative Organizations\(^{12,13}\)
- Management support
- Resource availability
- Implementation practices “hard wired”
- Champion
- Fit between innovation & values
- Effective innovation improves climate

Innovative Individuals\(^{12}\)
- Greater contact with change agents
- Actively seek information
- Greater knowledge of innovation
- Greater social participation
Stages of Innovation in Organizations

Initiation
- Agenda Setting
- Matching
- Redefining/Restructuring

Implementation
- Clarifying
- Routinizing

<table>
<thead>
<tr>
<th>8 Stages (Kotter)</th>
<th>Change Model (Pronovost)</th>
<th>Organizational Stages (Rogers)</th>
<th>Individual Stages (Rogers)</th>
</tr>
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<tbody>
<tr>
<td>Create Sense of Urgency</td>
<td>Engage</td>
<td>Agenda Setting</td>
<td>Knowledge – Persuasion</td>
</tr>
<tr>
<td>Build Guiding Team</td>
<td>Engage</td>
<td>Agenda Setting – Matching</td>
<td>Knowledge – Persuasion</td>
</tr>
<tr>
<td>Communicate for Understanding</td>
<td>Educate</td>
<td>Clarifying</td>
<td>Persuasion – Decision</td>
</tr>
<tr>
<td>Empower Others</td>
<td>Execute</td>
<td>Clarifying</td>
<td>Decision</td>
</tr>
<tr>
<td>Short-Term Wins</td>
<td>Execute – Evaluate</td>
<td>Clarifying - Routinizing</td>
<td>Implement</td>
</tr>
<tr>
<td>Don’t Let Up</td>
<td>Evaluate – Expand</td>
<td>Clarifying - Routinizing</td>
<td>Implement</td>
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<tr>
<td>Create a New Culture</td>
<td>Expand – Endure</td>
<td>Routinizing</td>
<td>Confirmation</td>
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Putting it All Together: The Checklist

✓ Clearly define the change
✓ Management is supportive
✓ Implementation Champion
✓ Employees recognize change is a priority
✓ Resources are available
✓ Policy/Procedure changed
✓ Job descriptions/performance appraisals changed
✓ Change is evaluated
✓ Results of evaluation guide improvement

Culture Change Comes Last, Not First! \(^{10}\)

- Changes in values come at the end of the transformation process
- New behaviors adopted by the laggards after success has been proven by the early adopters
- Feedback and reinforcement are crucial to using the behaviors—adopting
- Sometimes the only way to change culture is to change key people
- Individuals in leadership positions need to walk the walk and talk the talk

...Reculturing takes time and it really never ends
Explain the impact of a teamwork training program on hospital safety culture

• Kirkpatrick’s Taxonomy Four Level Taxonomy of Training Criteria

• Team training can result in transformational change in safety culture when the work environment supports the transfer of learning to new behavior
Kirkpatrick’s Taxonomy

RESULTS
Improved patient outcomes
Societal benefit

TRANSFER
Measurable aspect of job performance

LEARNING
Immediate knowledge, Knowledge retention
Skill demonstration

REACTIONS
Affective Reactions (like the training?)
Utility judgments (use the training to make changes?)

6. Please describe one change you will make in your practice as a result of this training.

7. This training was well organized, using the scheduled time efficiently.

8. Use of role play and active exercises increased the effectiveness of this training.

9. Please tell us how we can improve the organization and effectiveness of this training.

Download Short Evaluation of TeamSTEPPS from http://www.unmc.edu/patient-safety/teamstepps_toolkit.htm
Relationship Between Training Criteria

- **Training**
- **Knowledge**
- **Adoption**

**False Start (n=9)**
- Training: 57%
- Knowledge: 16%
- Adoption: 7%

**Early/Late Majority (n=18)**
- Training: 58%
- Knowledge: 22%
- Adoption: 15%

**Early Adopter (n=9)**
- Training: 81%
- Knowledge: 36%
- Adoption: 26%
Complete Some/All TeamSTEPPS Modules
Define Brief
Define SBAR
Define CUS
Define STEP
Use SBAR to communicate in dept
Use CUS to advocate for pt
Use structured communication across depts
Call huddle to adjust workload
Debrief for improvement

Kirkpatrick’s Taxonomy

% of Respondents

2009 (Pre-TeamSTEPPS)  2010 (Post-TeamSTEPPS)

Knowledge
Transfer of new Knowledge to behavior

%
EVERY 5% Increase in team behaviors is significantly associated with an increased of ....

- 11% in communication openness
- 15% in teamwork within departments
- 22% in exchange of important patient information during shift change
- 24% in perception that hospital mgt is interested in patient safety before adverse events occur
- 25% in perception that serious mistakes don’t happen by chance
Summary

• Safety culture is the learned, shared beliefs and behaviors that reflect organization’s willingness to learn and whether safety is a priority

• There are multiple strategies to use an innovation such as TeamSTEPPS to change your culture; they all have common elements...
  – Urgency/Engagement/Agenda Setting...the reason to change
  – Develop the right team to guide the change; make sure they have the time and resources to do the work
  – Match a specific problem to a solution and communicate the vision! (targeted or transformational change)
  – Empower, clarify, make it routine...don’t give up!
    • Expect barriers...remember the penguins!

"If I had an hour to solve a problem I’d spend 55 minutes thinking about the problem and 5 minutes thinking about solutions." — Albert Einstein
Team training can result in transformational change in safety culture when the work environment supports transfer of learning to behavior. More positive safety culture is associated with fewer adverse events and greater patient satisfaction.

http://teamstepps.ahrq.gov


Evaluation

• On Friday 11/22/13 you will receive an email message with an invitation to click on a link to complete the evaluation

• If you do not have an email address or did not receive an email to complete the previous evaluation....contact me for a paper evaluation
Requirements

1. Attend two webinars in person OR watch the recordings that will be posted within 1 week of live presentation on our website
   http://www.unmc.edu/patient-safety/teamstepps_training.htm

2. Complete evaluations of the webinars by 12/15/13

3. Submit an action plan for implementing TeamSTEPPS in your unit/hospital by 12/15/13
Contact Information

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