

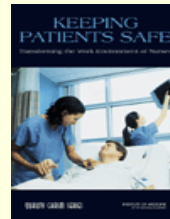
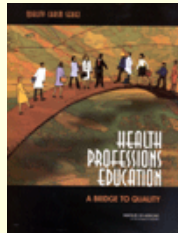
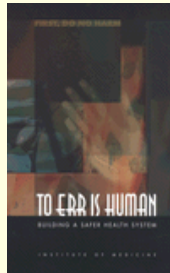
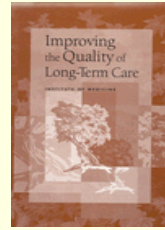
# Building A Culture of Quality

Angela Barron McBride, PhD, RN, FAAN  
Distinguished Professor & Dean Emerita  
Indiana University School of Nursing

## Overview of Presentation:

- The Institute of Medicine's various quality initiatives
- Responses to these reports
- The paradigm shifts taking place
- Concluding comments

# IOM's Quality Initiatives



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## Key Points:

- IOM's Quality of Health Care in America Committee was formed in 1998; their report *To Err Is Human* (2000) outlined an agenda:
  - *Focus national attention on patient safety;*
  - *Identify and learn from errors;*
  - *Set performance standards and expectations for safety; and*
  - *Implement safety systems in health care organizations*

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- *Crossing the Quality Chasm (2001)* articulated six aims for improvement:
    - Safety—avoid injuries to patients from the care that is intended to help them
    - Effectiveness—provide services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit
    - Patient-Centeredness—provide care that is respectful of and responsive to individual preferences, needs, and values

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- Timeliness—reduce waits and sometimes harmful delays for both those who receive and those who give care
  - Efficiency—avoid waste, in particular waste of energy, ideas, equipment, and supplies
  - Equity—provide care that does not vary in quality because of personal characteristics (e.g., gender, race/ethnicity, geography, socioeconomic status)

## Current Approach vs. New Rule

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- Care is based primarily on visits.
- Professional autonomy drives variability.
- Professionals control care.
- Information is a record.
- Care is based on continuous healing relationships.
- Care is customized according to patient needs and values.
- The patient is the source of control.
- Knowledge is shared and information flows freely.

- Decision making is based on training and experience.
- Do no harm is an individual responsibility.
- Secrecy is necessary.
- The system reacts to needs.
- Decision making is evidence-based.
- Safety is a system property.
- Transparency is necessary.
- Needs are anticipated.

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- Cost reduction is sought.
  - Waste is continuously decreased.
  - Preference is given to professional roles over the system.
  - Cooperation among clinicians is a priority.

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- *Health Professions Education: A Bridge to Quality* (2003) articulated five core competencies all health professionals must develop in the 21<sup>st</sup> century:
    - Provide **patient-centered** care;
    - Work as an **interdisciplinary** team;
    - Employ **evidence-based** practices;
    - Apply **quality improvement** methods; and
    - Utilize **informatics**

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- *Keeping Patients Safe. Transforming the Work Environment of Nurses* (2004) urged that attention be paid to organizational components:
    - *Transformational leadership and evidence-based management;*
    - *Workforce capability;*
    - *Design of work and workspace to prevent and mitigate errors; and*
    - *An organizational culture of safety*

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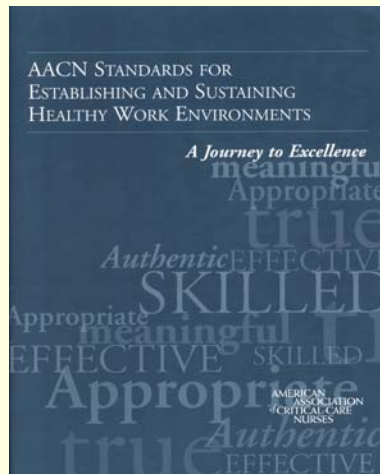
## Have these reports changed anything?

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- One professional association
- One nationally-focused interdisciplinary institute
- One hospital network

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## AACN Standards for the Healthy Work Environment (2005):

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

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# The Institute for Healthcare Improvement's Challenge:

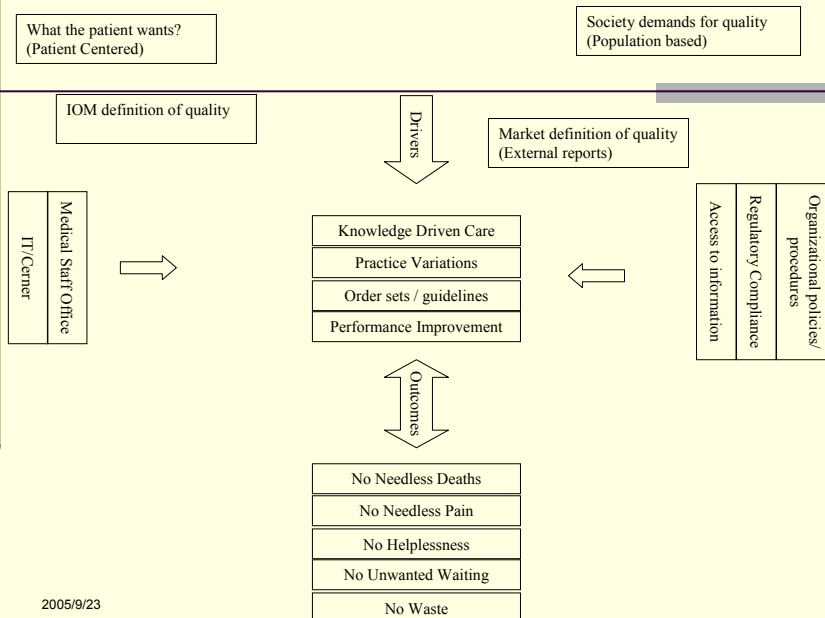
Save 100,000 lives by June 14, 2006:

- Rapid response teams
- Reliable care for acute myocardial infarctions
- Reliable use of ventilator associated pneumonia bundles
- Reliable use of central venous line bundles
- Surgical site infection prophylaxis
- Prevention of adverse drug events with reconciliation

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## Clarian Health: Becoming Second to None



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## Clarian Health in 2004: Third Largest Hospital Network in the United States

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- 360,542 patient days
- 56,900 admissions
- 72.9% occupant rate
- 54,200 surgeries
- 985 average daily census
- 6.37 average length of stay
- 1.6028 case mix index
- 901,155 out-patient visits
- 9730 FTEs

## Build A Culture of Safety: Become A Highly Reliable Organization (HRO)

# Highly Reliable Organizations

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- Goal: zero errors
- Examples: nuclear power plants, aircraft carriers
- Challenge for highly complex healthcare organizations

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# Reliability

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The measurable capability of a process, procedure or health service to perform its intended function in the required time under commonly and uncommonly occurring circumstances.

2003, IHI

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## Characteristics of Highly Reliable Organizations:

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- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise (the authority gradient does not become a barrier)

Weick (2001) Managing the Unexpected

## Three Levels of Safety

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- Design the system to **prevent** failure
- Design procedures to make **failures visible** so they may be **intercepted** before causing harm
- Design procedures for **mitigating the harm** caused by failures when they are not detected or intercepted

# Key Elements of a HRO

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- Systems, structures, and procedures conducive to safety and reliability are in place
- Intensive training of personnel and teams takes place via routine operations, drills and simulations
- Safety and reliability are examined **prospectively** for all the organization's activities; organizational learning by **retrospective** analysis of accidents and incidents is aggressively pursued
- A culture of safety permeates the organization

*Gaba, APSF Newsletter, Spring, 2003*

## Systems, structures, and procedures conducive to safety and reliability are in place

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- Baseline regulatory patient safety policies and procedures
  - Sentinel event policy
  - Disclosure
- Root Cause Analysis
- Patient Safety Infrastructure
  - Safe Passage (Patient Safety Knowledge Management Infrastructure)
  - Medication Safety Committee
  - Information Systems (alerts, reminders, etc)
- Implementation and Design of System Utilizing Patient Safety Concepts

# The Safe Passage Nurse Program

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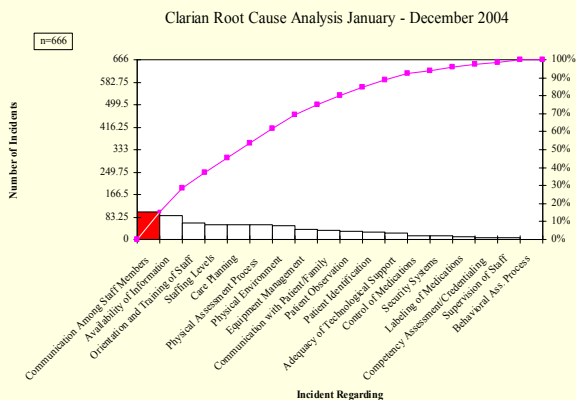
- The Safe Passage Nurse, designated by the unit to become the local safety expert
- Provides nurses with patient safety knowledge base
- Provides a communication network from top to bottom and bottom to top
- Prevents errors through planning for change
- Creates a mechanism to learn from errors
- Provides a mechanism for process improvement

# Communication Mechanisms

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- Safe Passage Newsletter
- Safe Passage Emergency Alerts
- Safe Passage List Serve
- Monthly Local Council and System Meetings
- Safe Passage Books for unit
- Safe Passage Name Badge Hang Tags

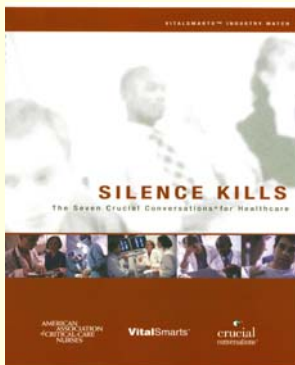
# Clarian Health: Root Causes of Sentinel Events



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# Healthcare professionals see errors; if they don't speak up, silence can kill



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## 1700 interviewed, identifying seven concerns:

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- Broken rules, e.g., shortcuts
- Mistakes
- Lack of support, e.g., refusing to answer questions
- Incompetence
- Poor teamwork—gossip, cliques
- Disrespect—yelling, swearing
- Micromanagement—bullying, pulling rank

## Addressing Communication Skills At Clarian Health

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- Phase 1: March is Patient Safety Month
  - Joseph Grenny, co-author of Crucial Conversations and “Silence Kills” Study, to speak at Clarian Health (March 18<sup>th</sup>)
- Phase 2: Teaching Healthy Communication
  - Collaboration/Training with VitalSmarts

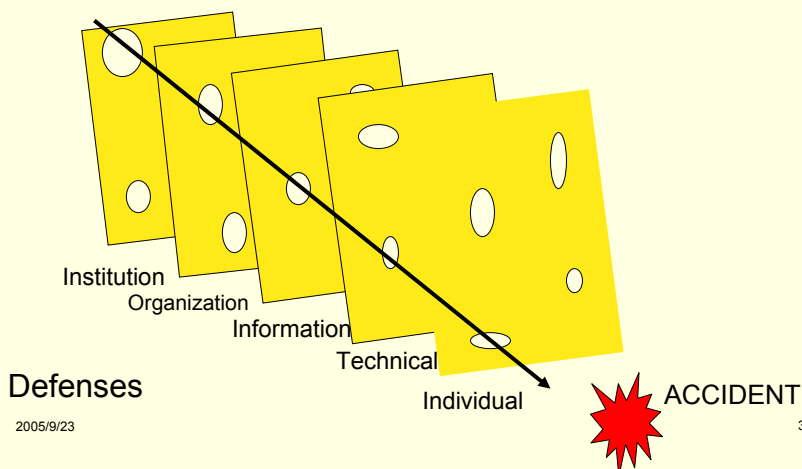
# Patient Safety Week: March 6-12

- One event is “Stump the Exec”
- Two teams of Clarian executives test their knowledge of patient safety issues and policies
- Some who are participating this year—CEO, General Counsel, Physician-in-Chief, Director of Pharmacy
- Moderator is a local television emcee

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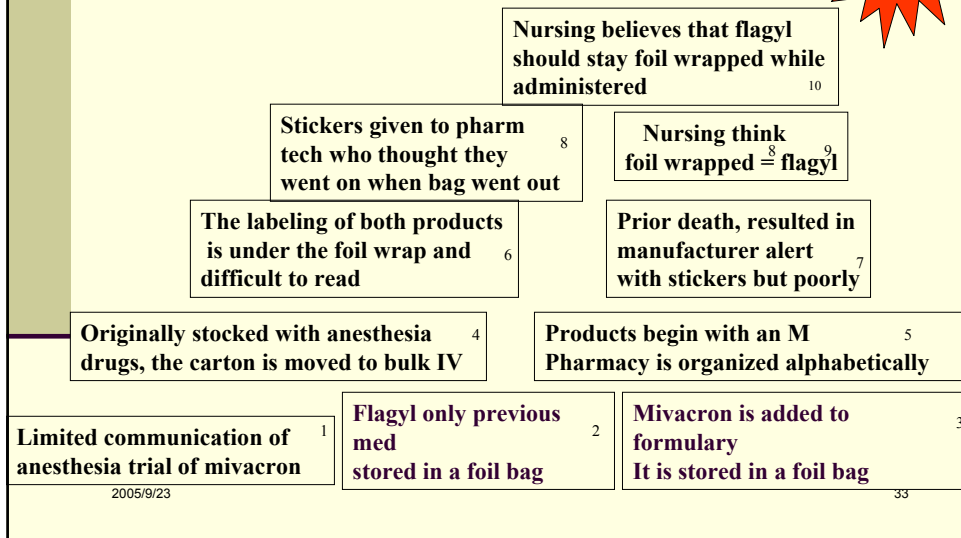
## Complex System Failure



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# An example of complex system failure



## Paradigm Shifts: Practice

- Do no harm is an individual responsibility
- Organized in terms of professional silos
- Workarounds the norm
- The focus of care is the patient's compliance with treatment
- Safety is a system property
- Organized to encourage interdisciplinary collaboration
- Crucial conversations the norm
- The focus of care is best practices and quality outcomes (benchmarking 95<sup>th</sup> percentile)

## Paradigm Shifts: Education

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- Teacher as “sage on stage”
- Emphasis on memorization of facts
- Focus on nurse-patient relationship
- Teacher as “guide by side”
- Emphasis on using data/information for decision making
- Focus on the hospital as a learning organization

## Concluding Comments

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- The IOM’s quality initiatives have been as successful as they have been because the various reports built on each other for synergistic effect.
- Clarian Health has followed a similar strategy in producing an annual Quality Plan; the various initiatives—education, infection control plan, outcomes management, order set management, regulatory compliance, etc.—reinforce the overall commitment to be “second to none.”

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- Committed to quality and believing that reimbursement will eventually be determined by scorecards demonstrating excellence, Clarian Health has joined various national initiatives, e.g., National Surgery Quality Improvement Project, Leapfrog, National Trauma Registry, Centers for Medicare and Medicaid Services, VitalSmarts. Staff consequently take pride in being cutting-edge in their work.

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## Thank You....Thank You....

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- Dan Evans, CEO, Clarian Health
- Sam Odle, CEO, Methodist Hospital of Indianapolis and University Hospital
- Richard Graffis, MD
- Sam Flanders, MD
- Karlene Kerfoot, PhD, RN
- Barbara Brewer, PhD, RN
- Pat Ebright, DNS, RN
- Kathy Rapala, JD, RN

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