Culture, Systems and Systems Change

What Is Involved in Making Major Change

- Tackling the core issues
- The basis for success
- The underlying essentials
- The process
- Tools to changing your system

A Process for Improving Results

- Get Senior Leaders whole-hearted support
- Get the key others on the team
- Establish a basic objective or objectives
- Understand the current culture
- Modify the current culture
- Initiate the improvement process
- Identify a way to know improvement
- Create a supply of possible improvements

"The slightest voice inflection, the most innocent remark, can land hard on those you have authority over, causing them to make up stories that support increased caution and distort further interaction."

Goleman et al **Primal Leadership** 2013

Preparing for Change

Hospitals vary in organizational culture, and the type of culture relates to the safety climate within the hospital. These results suggest a healthcare organization's culture is a critical factor in development of its patient safety climate and in the successful implementation of quality improvement initiatives. *British Med Journal*

Organisational Culture: Variation Across Hospitals and Connection to Patient Safety **Guide**

Safety Culture Definition

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

Study Group on Human Factors. Organising for safety: third report of the ACSNI (Advisory Committee on the Safety of Nuclear Installations). Sudbury, England: HSE Books; 1993.

What makes a caring culture hard?

- Caring is largely empathy
  - Empathy means accepting the emotion the other person feels
- Health care providers often feel a need to be aloof
- Maybe we don’t want to change that?
- Can we treat co-workers one way and consumers another?
- So what’s the answer?

What is Culture?

Group	Grievance
Doctors	Working as glorified billing clerks to insurance companies & abuse by system leads to burnout
Nurses	Volume-driven disregard for patient safety and understaffing cause major stress (focus on computer data entry instead of bedside care)
Middle class	Healthcare's hyperinflation caused an economic depression and is #1 driver of bankruptcy
Millennials	Their healthcare "bill" makes their college debt look small and will make them indentured servants to healthcare
School leaders and advocates	Healthcare has stolen budgets and poor public health creates challenges for students that manifest in the classroom
Seniors and soon-to-be seniors	Risky, uncoordinated care is frustrating and costly; nest eggs have been crushed

Areas of Concern

- Dealing with each other
- Dealing with leadership
- Dealing with the client/consumer/patient
- Dealing with concerned supporters
- Dealing with advocates
- Dealing with the public non-utilizers

How Do We Identify the Culture

Use a standard instrument for evaluation

Links to AHRQ information on measuring Culture (Below)

http://www.ahrq.gov/qual/patientsafetyculture/usergd.htm

http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html

http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html?utm_campaign=20161028&utm_medium=Email&utm_source=SOPSanc

Sample Questions from Hospital Survey on Patient Safety

Measured on a scale of agree-disagree

1. People support one another in this unit
2. We have enough staff to handle the workload
3. When a lot of work needs to be done quickly, we work together as a team to get the work done
4. In this unit, people treat each other with respect
5. It is just by chance that more serious mistakes don't happen around here
6. We work in "crisis mode" trying to do too much, too quickly
7. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts

Patient Safety Culture Composite	Definition: The extent to which…
Communication Openness	Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority.
Feedback and Communication Error About	Staff are informed about errors that happen, are given feedback about changes implemented, and discuss ways prevent errors.
Frequency of Events Reported	Mistakes of the following types are reported: (1) mistakes caught and corrected before affecting the patient, (2) mistakes with no potential to harm the patient, and (3) mistakes that could harm the patient but do not.
Handoffs and Transitions	Important patient care information is transferred across hospital units and during shift changes.
Management Support for Patient Safety	Hospital management provides a work climate that promotes patient safety and shows that patient safety top priority.
Non-punitive Response to Error	Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.
Organizational Learning—Continuous Improvement	Mistakes have led to positive changes and changes evaluated for effectiveness.

Patient Safety Culture Composite	Definition: The extent to which…
Staffing	There are enough staff to handle the workload and work hours are appropriate to provide the best care for patients.
Supervisor/Manager Expectations and Actions Promoting Patient Safety	Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.
Teamwork Across Units	Hospital units cooperate and coordinate with one another to provide the best care for patients.
Teamwork Within Units	Staff support each other, treat each other with respect, and work together as a team.
Overall Perceptions of Patient Safety	Procedures and systems are good at preventing errors and there is a lack of patient safety problems.

Guidelines for Cultural Change

- Formulate a clear strategic vision
- Display top-management commitment
- Model culture change at the highest level
- Modify the organization to support organizational change: identify current systems, policies, procedures and rules to be changed to align with the new values & desired culture.
- Select and socialize newcomers and terminate deviants.
- Develop ethical and legal sensitivity
- Include a periodic evaluation process to monitor the change progress and identify areas that need further development.

Creating a Team

- Senior Executive Champion (CEO,COO,CFO, Someone similar)
- Team Leader with authority: ED Director?
- Key technical leaders: Physician champion

  behavioral health leader, general medical leader
- Others with imagination

Changing Systems

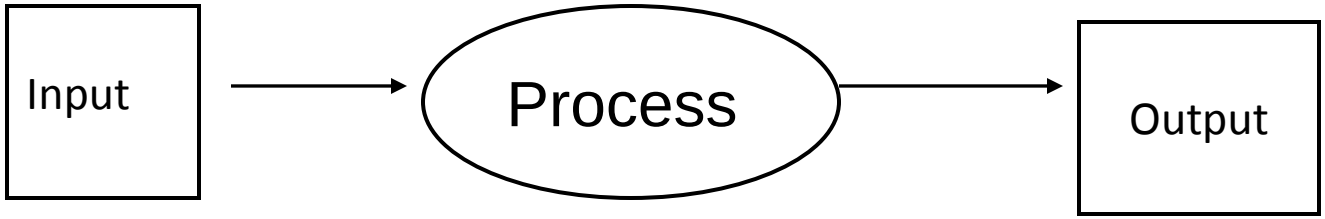
- Striving to improve is the way we anticipate the future – otherwise we are passive objects on the sea of life
- To create the future, instead of letting it happen to us, we imagine a different future and begin to build it
- The start is recognizing **what bothers us**
- By testing small changes we find out what works - better
- Data collection lets us know the results

Systems and Changing Systems: A framework for improvement

- What is a system, why should we care
- How do we change a system
- The Model for Improvement
- Establishing an aim
- The process for achieving a useful change
- Measuring results

What is a system, why should we care ?

System components



- “Every System is perfectly designed to achieve the result it gets.”

- “If you want a different result, you have to change the system.”

  Donald Berwick, MD and others

- What is input?
  - Labor, materials, money, knowledge, Consumers
- What is Output?
  - Outcomes, placements, healing, happier consumers
- What is Process?
  - What happens to Input to achieve output

It is not the strongest of species that survives, nor the most intelligent, but the one most responsive to change.

--Charles Darwin

Quality Improvement vs. Quality Assurance

- Quality Assurance
  - Matching standards
  - Controlling
  - Punitive
  - Closed
- Quality Improvement
  - Creating new standards
  - Empowering
  - Rewarding
  - Open

Getting a Better Result

- Establish a goal
- Understand and manage the culture
- Identify a process
- Involve others
- Try changes
- Measure results
- Repeat

Key Questions

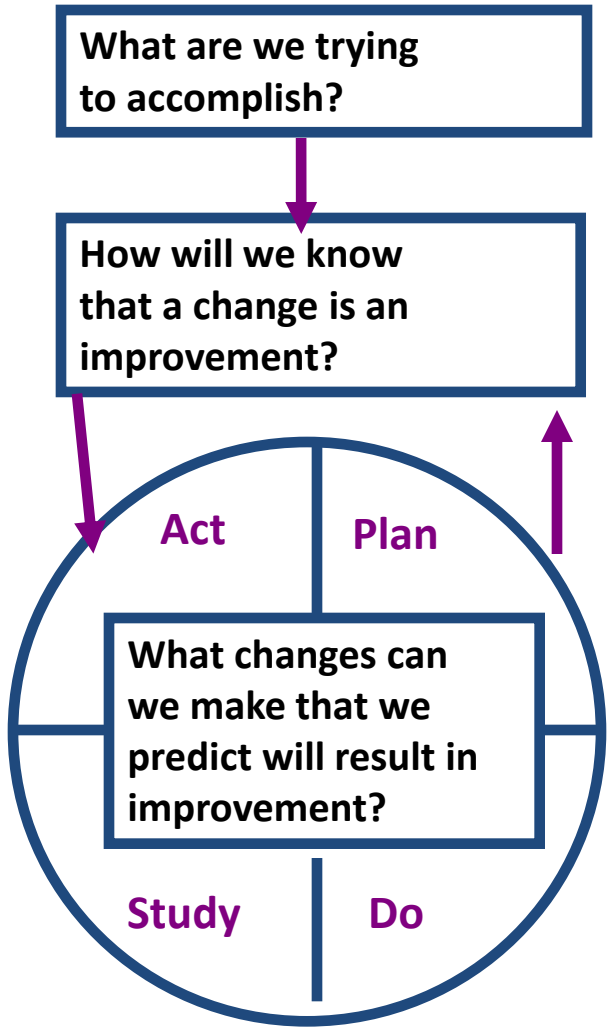
- What are we trying to accomplish?
- How will we know we have made an improvement?
- What changes can we make that we predict will result in improvement?

Model for Improvement

Aim

Measures

Cycle for Learning &Improvement



Starting Improvement

- **Involve senior leaders**

  Leadership must align the aim with strategic goals of the organization.
- **Base your aim on data**

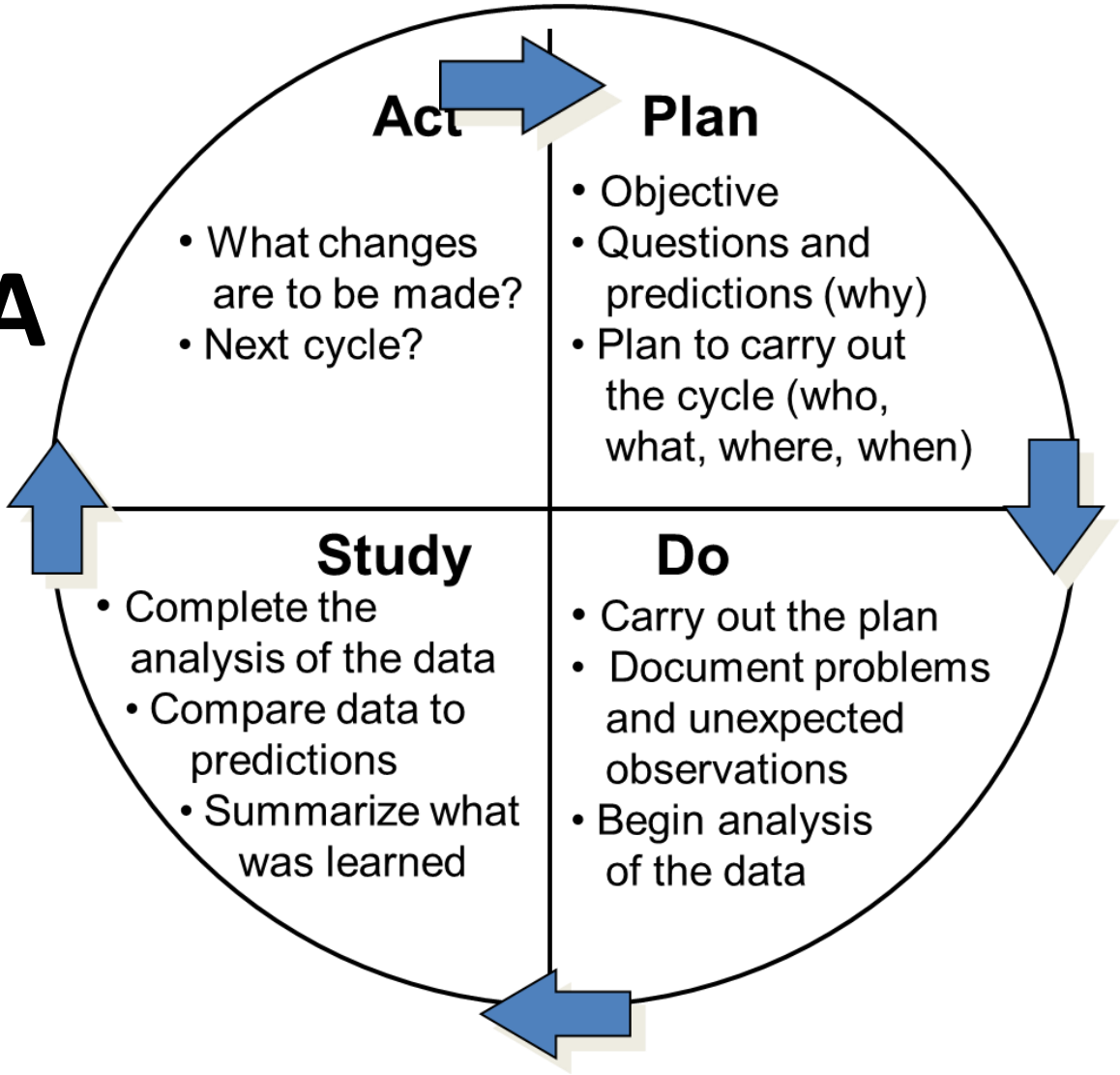
  Examine satisfaction and performance data within your organization. Set **goals** in the Improvement Charter and focus on issues that matter.
- **State your aim clearly and use numerical goals**
  Unambiguous, specific aims make for better progress. Setting numerical targets clarifies the aim, helps to create tension for change and directs measurement

Example of Aim Statement

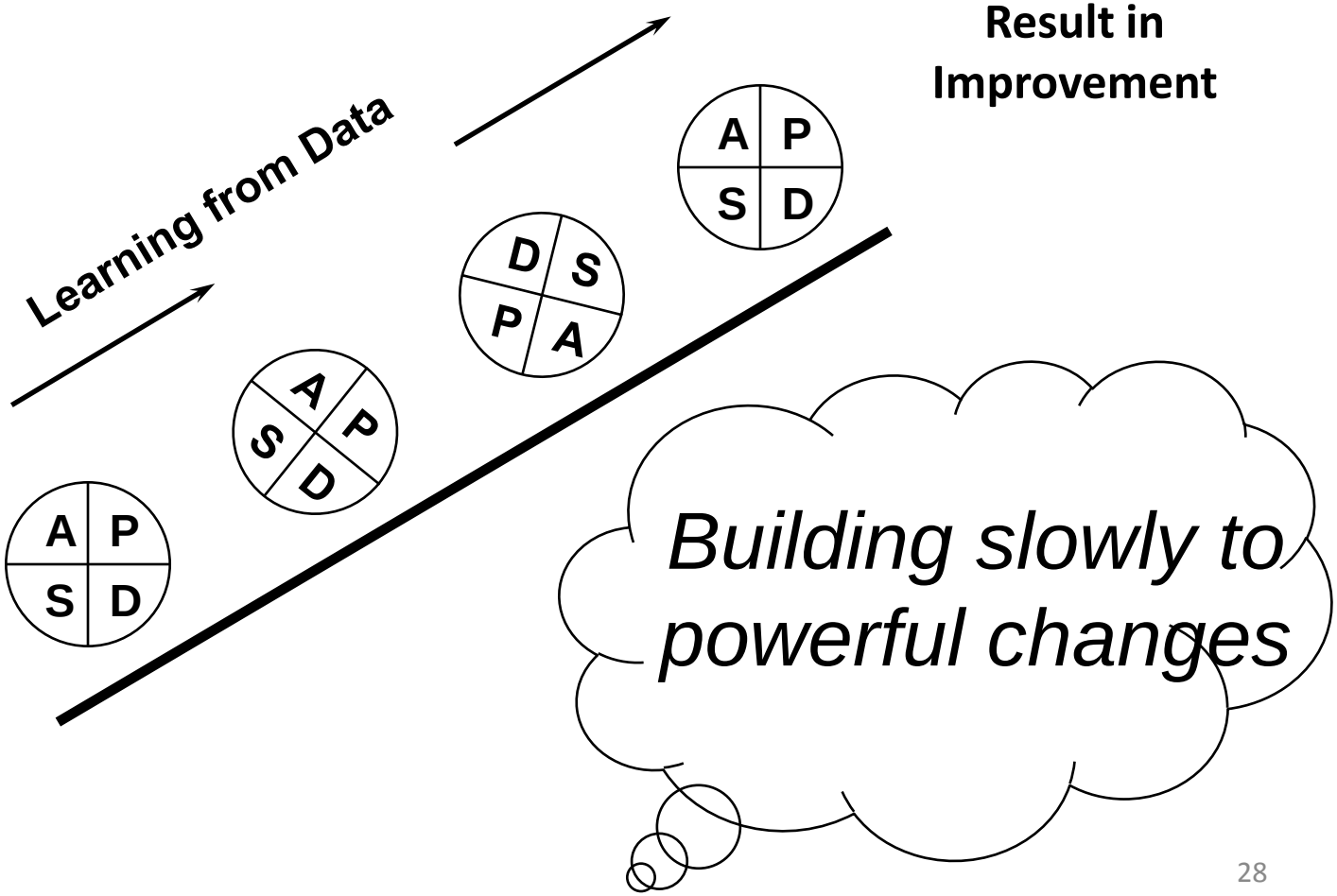
(Some is not a number, Soon is not a time)

- Reduce the average length of stay to three hours
- Reduce the rate of use of restraint to no more than 1% of intake
- Improve the discharge to home rate to 65%
- Reduce returns within 30 days to 15%

The PDSA Cycle



Repeated Use of the PDSA Cycle



Why Test?

- Increase the likelihood the change will result in improvement
- Predict how much improvement can be expected from the change
- Minimize resistance upon implementation
- Learn how to adapt the change to conditions in the local environment
- Evaluate costs and side-effects of the change

Types of Measures

- Outcome Measures
  - **Results - system level performance**
- Process Measures
  - **Inform changes to the system**
- Balancing Measures
  - **Signal "robbing Peter to pay Paul"**

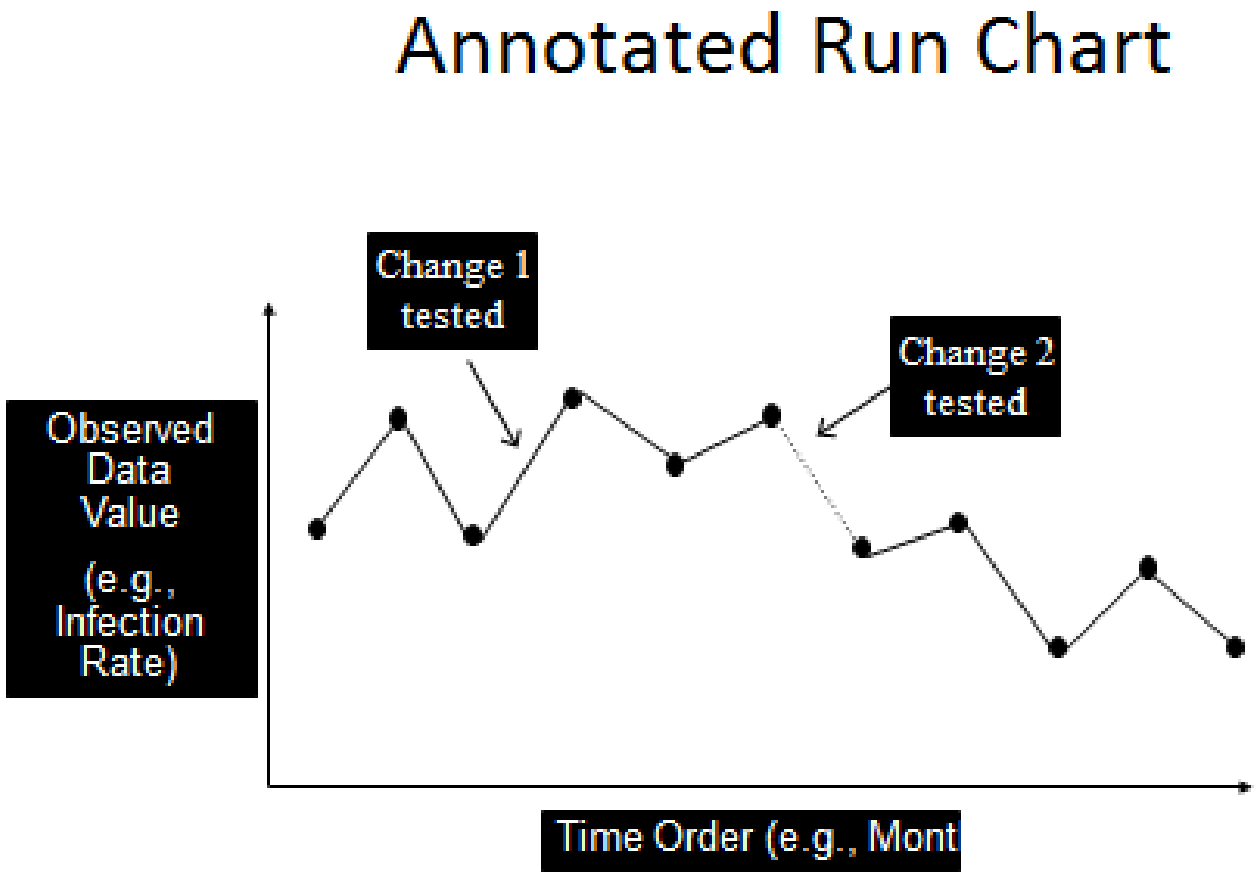
Measurement: Guidelines

- Need a balanced set of 4 to 8 measures reported each month to assure that the system is improved.
- These measures should reflect your aim statement & make it specific
- Measures are used to guide improvement and test changes. They must be identifiable.
- Integrate measurement into daily routine
- Plot data for the measures over time and annotate graph with changes

Some Measurement Assumptions

- The purpose of measurement is for *learning* not judgment
- All measures have limitations, but the limitations do not negate their value
- Measures are one voice of the system. Hearing the voice of the system gives us information on how to act within the system
- Measures tell a story; goals give a reference point

Using Run Charts



- Plot small samples frequently over time

Identifying Your Issues

- Gather data on length of stay, restraints, satisfaction and other key issues you identify
- Interview five (5) people who recently went through the ED
  - Why did they come
  - What was the result
  - What did they like and not like
- Have a staff person go through becoming a client

Some Typical Issues Complicating Change

- Staffing very limited
- No effective, or rigid, hierarchy of management
- Lack of staff concern for behavioral health issues
- Physical space constricted and in demand
- No flexibility in space utilization
- Waiting area disconnected from treatment area
- General health staff not trained to see/treat BH symptoms
- No expedited care for general health emergencies
- Hospital protocols not related to needs
- Fear of adverse outcomes drives unnecessary admissions
- Staff hardened to the ED environment
- Security staff eager to assure they have a role
- Some staff may see development of welcoming environment as encouraging undesired behavior such as overuse

7 Actions All Leaders Must Take When Guiding Change: Art Petty's Leadership Caffeine™

1. **Show respect for your employees by providing advanced and in-depth context for internal or strategy changes.**
2. **Give people a voice in how changes will be implemented.**
3. **Solicit ideas that may minimize or eliminate the need for adverse changes**.
4. **Teach people about the business drivers behind change.**
5. **It's a process, not an event!** Set up feedback loops and allow people to adjust and improve on the fly.
6. **Answer the burning question.** ***"What does this mean for me?"***
7. **Don't shoot yourself in the credibility foot.** (By doing dumb counter productive things)