**Innovation, Change and Patient Safety**

It’s been ten years since the first law that linked payment from federal health programs to data from hospitals. To ramp up the quality initiative, incentives were first based on reporting data; now payments are linked to the actual data in “pay for performance.” Unfortunately, the reports on the Hospital Compare website emphasize process measures for acute MI, community-acquired pneumonia, heart failure and children’s asthma rather than outcomes. The mortality and readmission data currently reported is incomplete for most hospitals, and rather than publicly reporting actual numbers, hospitals are instead compared to the “national rate.”

While we may know that fewer people have hospital-acquired infections, for example, do we know if fewer people die?

**Incentive Programs**

“Pay for performance” has focused administrators like a laser on these core measures, which now include patient satisfaction. But what about the patients whose diagnosis or characteristics do not contribute to the incentivized measures? Or, when keeping a patient “happy” conflicts with appropriate care? While reimbursement is essential to keep a hospital open, clinicians are motivated to provide the best possible care to all patients. Our incentives are intrinsic – our professionalism.

Clinicians want to do the right thing. It’s rarely a lack of knowledge but rather a surplus of barriers that get in the way. Guideline documents are long, detailed and often ambiguous. So, checklists were born. They pare complex recommendations into simple, clear action steps. The most effective incentives for clinicians are those that make it easy to do the right thing.

**Lessons Learned from Keystone**

Peter Pronovost, MD of Johns Hopkins recently presented a webinar in which he shared lessons learned from the Keystone Project in Michigan that dramatically reduced CLABSI rates.1 These lessons are not limited to this project, but apply to any clinical change project.

- **While standardization is an admirable goal, every process implementation has to be developed with front-line clinicians where local wisdom guides modifications at the unit level.** 95% of checklists are the same, but that customized 5% is usually the key to successful implementation because it addresses unique barriers.

- **Adaptive work – the human aspect of change – is just as valuable as the technical aspects of task modification.** Informal authority that comes from trust of the team is more powerful than any title.

- **Establish a climate of clinician engagement, transdisciplinary interactions, community, and teamwork regardless of the technical change.** Develop additional checklists of tasks that allow hospital boards and administrators to support the clinicians’ work.

- **Adjust expectations.** Instead of treating complications as inevitable, for example, treat each as unacceptable and investigate causes. Change is possible only when clinicians can see harm as a serious problem that can be improved or see the benefits of a new way of doing things.

- **Share experiences and tell stories.** They facilitate a personal connection among team members.

The voice of the bedside clinician is essential to the process. Focus should be on the directly responsible individual, not the HIPPO (highest paid person’s opinions).

Pronovost noted that it’s a common misconception that people resist change. He said that no one would turn down lottery winnings even though suddenly becoming a millionaire would be a significant change! People actually resist loss – losing the comfort of routine and predictability that comes with the way things have always been done. We can reduce that sense of loss by explaining why clinicians should be using a new checklist or piece of equipment or process (with a compelling story whenever possible) and by seeking to understand any resistance. He says, “Learn, don’t judge.”

**Translate Research Into Practice**

In response to the landmark studies on medical errors from the Institute of Medicine, researchers noted a lack of empirical evidence to demonstrate improved safety. The mother of an 18 month old who died from dehydration and improper opioid administration after being saved from serious burns asked, “Is my daughter less likely to die today than before?”2 Since her care providers could not immediately say, “Yes!” they knew they had to work harder to create high reliability in health care organizations.3

Researchers turned to another high-reliability organization, aviation, to analyze how to overcome challenges and barriers to maintain significantly reduced defect rates. Researchers came up with a comprehensive approach to measure patient safety and then support the culture and processes that work and modify those that do not. The structure – how care is organized, plus the process – what we do, determines outcomes. Each of these elements depends on a supportive culture for success.

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In the Literature

Do As I Say, Not As I Do

A study reported in the current issue of the *American Journal of Infection Control* asked 488 student nurses to complete a questionnaire comparing what they learned about infection control practices with what they observed in their clinical practice rotations. For 19 items respondents indicated the degree to which they had witnessed lapses, ranging from never to daily. Highest reported noncompliance was hand hygiene (76%), wearing rings (61%), artificial nails and nail polish (60%), and not wearing PPE for isolation (59%). Best compliance was noted for using gloves for urinary catheter insertion (noncompliance 5%) and not reusing single-use items (noncompliance 8%). What would the results be on your unit? Source: Gould D, et al: Student nurses’ experiences of infection prevention and control during clinical placement. *AJIC* 2013; 41(9):760-763. PubMed Citation

Still Eating Our Young

In the current issue of the *Journal of Nursing Scholarship* results of a national survey of 1407 RNs are reported by New York nursing researchers examining verbal abuse from nurse colleagues. RNs experiencing abuse were mostly white, married females who were primary English speakers, did not have children younger than age 6, and worked in an acute care hospital on 12-hour day shifts. They also reported that fewer RNs than scheduled were working when abuse occurred. Highest levels of abuse were directed at RNs least likely to be married, have young children, be in excellent health and work in a Magnet® hospital. Those working in ICUs and on 8-hour shifts were least likely to report high levels of verbal abuse from nurse colleagues. The authors note little effect from the attention paid to horizontal violence, and call for evidence-based strategies to reduce the abuse and to help nurses deal with it if it does occur. Source: Budin WC: Verbal abuse from nurse colleagues and work environment of early career registered nurses. *Journal of Nursing Scholarship* 2013;45(3):308-316. PubMed Citation

Strategy for Change

Within this framework, there are four steps for leading change:

- **Engage**: use stories to get people started thinking about how each can create an organization or unit that is optimal for patients and rewarding for staff
- **Educate**: clearly answer the question “what do I need to do?” to implement the change; ensure that front-line staff know why the change is essential, how daily workflow will be different, how they will know the change was successful, and where to get support during the change process
- **Execute**: identify barriers as quickly as possible and resolve them, ensure that front-line staff have the resources to succeed, encourage teamwork and active problem-solving
- **Evaluate**: ensure everyone knows how they made a difference, share data openly and reinforce how people know care has improved

On the CUSP

The Comprehensive Unit Safety Program (CUSP) was designed to improve safety culture and learn from mistakes by integrating safety practices into the daily workflow. While the model’s initial intent was addressing safety issues, its principles apply to any clinical change process. The steps are:

1. **Establish the science of safety**: conceptual framework, system properties, principles of safe workflow
2. **Staff identify defects**: depend on those doing the work to identify the problems with the work
3. **Senior executive partnership**: bridge the gap between executives and the bedside, use executive clinical rounds, rely on the executive to remove administrative barriers
4. **Learn from defects**: examine the defect, identify contributing factors, implement workflow changes to reduce the probability of recurrence, summarize learning
5. **Tools to improve**: improve communication, teamwork, and other key unit-specific hazards

In *On the Web*, you’ll find a wealth of free resources on the CUSP model and its implementation. Together with information on making the financial case for change in the last issue of this newsletter, you now have the tools to move forward. All you need to add is the motivation.

Sources

1. Pronovost PJ: Taking quality to the next level: together we achieve. Webinar presented on September 18, 2013; Available at http://www.webbertraining.com/