Learn it, Lead it, Live It: Strategies for Creating a Culture of Safety at the Frontline

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Self
Number 1 Respected Profession

Nursing

Gallup Poll: 82% Honesty & Ethical Rating

So Why Don’t We Feel Respected?
Reclaiming Respect

What Behaviors or Communications Make You Feel the Recipient of Respect?

Work Environment

Quality of Care You Provide to Patient & Families whether directly or indirectly
Feeling of Respect or Not being Respected

- Respected
  - Feeling listened to
  - Feeling revered for their knowledge
  - Feeling trusted
  - Feel part of the group
  - Being acknowledged
  - Sense of belonging/contributing
  - Persons look out for each other and their support
  - Fairness
  - Free to speak
  - Opportunities to excel

- Not Being Respected
  - Disregarded
  - Not revered
  - Not trusted
  - Not supported
  - Not recognized
  - Closed conversation
  - Speaking in a tone that is demeaning
  - Ideas and opinions not considered a value priority
  - Unsafe, guarded, pressured, put down

The Nature and Causes of Disrespectful Behavior

- Barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect
  - Disruptive behavior
    - Inappropriate conduct, outburst, verbal threats, bullying
  - Humiliation, demeaning treatment
  - Passive aggressive behavior
    - Pattern of negativistic attitudes & passive resistance to adequate performance
  - System disrespect
    - Patient waiting, hostile working conditions, fail to ensure the physical safety of staff.

Leape LL, et al. Academic Medicine, 2012;87(7):845-852
The Nature and Causes of Disrespectful Behavior

• Disrespect does the following;
  – Immediate aftermath; experience fear, anger, confusion, self-doubt, that can lead to error in decision-making
  – Long-term effects; Avoid the person inflicting hurtful behavior
  – Inhibits collegiality and cooperation key to teamwork
  – Cuts off communication
  – Undermines morale
  – Inhibits compliance and implementation of new practices
  – Diminishes joy and fulfillment in work and increases turnover

Leape LL, et al. Academic Medicine, 2012;87(7):845-852
Respect

Self Respect
Self Respect

Internal Dialogue

External Dialogue
The Road to Respect

I spoke.
You listened.
I felt valued and honored.
You shared your opinion.
I trusted your wisdom.
The circle of respect was complete.
We saw in each other’s eyes are common humanity.
Now, moving to a zone of mutual affirmation, we felt safe to trust and learn and nurture in the give-and-take of life.

Yasmin Morais 2006
Advocacy
Advocacy can be seen as a deliberate process of speaking out on issues of concern in order to exert some influence on behalf of ideas or persons.

http://en.wikipedia.org/wiki/Advocacy accessed 03/05/2009
Broaden the Definition of Advocacy

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”

Florence Nightingale
Notes on Hospitals: 1859

Advocacy = Safety
Patient Advocacy/Safety Related to Clinical Practice

- Knowledge of the best practice
- Ability to deliver the care to the right patient at the right time, every time it is needed
- The ability to communicate concerns in a concise, data driven manner and take appropriate action
- Understanding that I am the voice of the patient
Why Effective Communication May Be Challenging

- Self Respect
- Communication
- Advocacy
- Teamwork
- Safety
- Environment
The Silent Treatment: April 2011

- 85% of workers - safety tool warned them
- Safety tools include: handoff protocols, checklists, COPE, automated medication dispensing machines.
- 58% said they got the warning but didn't speak up
- 1/2 say shortcuts lead to near misses
- 1/3 say incompetence leads to near misses
- 1/2 say disrespect prevented them from getting others to listen or respect their opinion

Only 16% confronted the disrespectful behavior

http://www.silenttreatmentstudy.com
OSHA: Definition of Workplace Violence

“Any physical assault, threatening behavior or verbal abuse occurring in the work place”

Study of 8780 staff from 210 hospitals found that 46% of nurses experience 1 or more types of violence (emotional abuse, threats, physical assault, verbal sexual harassment & sexual assault in the past 5 shifts they worked-most is patient to worker

Almost 70% of abuse towards nurses & doctors is not reported

Joint Commission. Sentinel Event Alert Issue 59, April 17, 2018
“Our lives begin to end the day we become silent about things that matter”

Martin Luther King Jr.
JC Sentinel Event Alert: Physical & Verbal Violence Against Health Care Workers

• Workplace violence directed at health care workers by patients and families
  – 75% of reported workplace assaults occur in health care or social services setting
  – Emergency room and inpatient psychiatric setting record most incidence
  – All types of health care workers impacted
  – Significantly under reported

• Impact:
  – Low staff morale
  – High worker turn over
  – Lawsuits

https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf
Leadership Commitment

+ Worker Participation

Using customized evidence-based solutions

= A Safer Workplace
• Clearly define workplace violence and systems in place for easy reporting
• Data comes from several sources—include those that may not have caused harm
• Appropriate follow up and support to victims
  – Psychological counseling
• Review each case to determine contributing factors
• Develop quality improvement initiatives to reduce incidents.
  – Changes to physical environment
  – Changes to practices or administrative procedures
• Train all staff including security in de-escalation, self defense and response to emergency codes

https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf
Understanding Your Culture & Communication Strategies

How are you going to participate in fixing it?

Have you talked to......

If you Permit it you Promote it

Tweeners

Negatoids

Positrons
A good word is an easy obligation; but not to speak ill requires only our silence; which costs us nothing.

John Tillotson
What to Do Individually?

- Prevent from occurring through training on effective communication
- Deal in real time to prevent staff or patient harm
- Initiate post event reviews, action and follow-up
- Make it as transparent as possible
- Zero-tolerance policy and procedure
- Intervention strategy: code white
Communication Training
Communication Strategies

• Tools to help structure communication
  – SBAR for communication with Doctors: Situation, Background, Assessment and Recommendation
  – CUS Words: I am Concerned, I am Uncomfortable, This is not Safe

Use CUS words when assertion of your communication fails…things go wrong…concern expressed but mutual decision not reached or proposed action doesn’t happen in time frame agreed upon
Courage

“Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen”

Winston Churchill
What to Do as An Organization?
Comprehensive Unit-Based Patient Safety Program (CUSP)

- Assess culture of safety (SAQ & AHRQ)
- Educate staff on science of safety
- Identify defects
- Learn from one defect per quarter
- Assign executive to adopt unit
- Implement team/communication tools
- Reassess culture annually

http://www.onthecusphai.org/
A healthy culture begins with each person & is enhanced by self work, healthy relationships & system supports

Ulrich B, et al. CCN, 2019;Feb online
“A fundamental principle has to be the development and then enforcement of procedures and standards. We can’t make real progress without them. When a (caregiver) doesn’t follow them, something has to happen. Today, nothing does, and you a have vicious cycle in which people have no real incentive to follow the rules because they know there are no consequences if they don’t. So there are bad doctors and bad nurses, but the fact that we tolerate them is just another systems problem.”

Dr. Lucian Leape
Balance No-Blame with Accountability is a Just Culture

- A system that:
  - Holds itself accountable
  - Holds staff members accountable
  - Has staff members who hold themselves accountable
Fundamentals
Missed Nursing Care

- Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.
- A predictor of patient outcomes
- Measures the process of nursing care

SORRY WE MISSED YOU!

Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.

## Patient Perceptions of Missed Nursing Care

<table>
<thead>
<tr>
<th></th>
<th>Fully Reportable</th>
<th>Partially Reportable</th>
<th>Not Reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently Missed</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Mouth care</td>
<td>Ambulation</td>
<td>Patient assessment</td>
</tr>
<tr>
<td></td>
<td>Listening</td>
<td>Discharge planning</td>
<td>Surveillance</td>
</tr>
<tr>
<td></td>
<td>Being kept informed</td>
<td>Patient education</td>
<td>IV site care</td>
</tr>
<tr>
<td>Sometimes Missed</td>
<td>Response to call lights</td>
<td>Medication administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Response to alarms</td>
<td>Repositioning</td>
<td></td>
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<tr>
<td></td>
<td>Meal assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain medication and follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely Missed</td>
<td>Bathing</td>
<td>Vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hand washing</td>
<td></td>
</tr>
</tbody>
</table>

* IV, intravenous.

Kalisch, B et al. (2012). TJC Jour Qual Patient Safety, 38(4),
Protect The Patient From Bad Things Happening on Your Watch

Implement Interventional Patient Hygiene
Interventional Patient Hygiene

- Hygiene...the science and practice of the establishment and maintenance of health
- Interventional Patient Hygiene....nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence based hygiene care strategies

Incontinence Associated Dermatitis Prevention Program
INTERVENTIONAL PATIENT HYGIENE (IPH)

VAP/HAP

Oral Care/ Mobility

HAND

Patient

HYGIENE

Skin Care/ Bathing/Mobility

Catheter Care

CA-UTI

CLA-BSI

SSI

Falls

HASI

Vollman KM. Australian Crit Care, 2009;22(4): 152-154
Achieving the Use of the Evidence

Factors Impacting the ability to Achieve Quality Nursing Outcomes at the Point of Care

Preventing NV-HAP Through Evidence Based Fundamental Nursing Care Strategies
Why NV-HAP?: DO NO HARM

• HAP 1st most common HAI in U.S.
  – Increased morbidity $\rightarrow$ 50% are not discharged back home
  – Increased mortality $\rightarrow$ 18%-29%
  – Extended LOS $\rightarrow$ 4-9 days
  – Increased Cost $\rightarrow$ $28K$ to $109K$
  – 2x likely for readmission <30 day

• Understudied, under-addressed
• Focus has been on the other HAP $\rightarrow$ VAP
• Surveillance not required….yet

Kollef M.H. et.al. (2005). Chest. 128, 3854-3862
Pathogenesis → Prevention

Germs in Mouth
- Dental plaque provides microhabitat
- Bacteria replicate 5X/24 hrs

Aspirated into Lungs
- Most common route
- 50% of healthy adults micro-aspirate in sleep

Weak Defenses
- Poor cough
- Immunosuppressed
- Multiple co-morbidities
NV-HAP SMCS Research Findings: 2010

Incidence:
- 115 adults
- 62% non-ICU
- 50% surgical
- Average age 66
- Common comorbidities:
  - CAD, COPD, DM, GERD
- Common Risk Factors:
  - Dependent for ADLs (80%)
  - CNS depressant meds (79%)

Cost:
- $4.6 million
- 23 lives
- Mean Extended LOS 9 days
- 1035 extra days

Phase 1: Oral Care

- Formation of new quality team: Hospital-Acquired Pneumonia Prevention Initiative (HAPPI)
- New oral care protocol to include non-ventilated patients
- New oral care products and equipment for all patients
- Staff education and in-services on products
- Ongoing monitoring and measurement
  – Monthly audits

# Protocol – Plain & Simple

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Tools</th>
<th>Procedure</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Care / Assist</td>
<td>Brush, paste, rinse, moisturizer</td>
<td>Provide tools</td>
<td>4 X / day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brush 1-2 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rinse</td>
<td></td>
</tr>
<tr>
<td>Dependent / Aspiration Risk</td>
<td>Suction toothbrush kit (4)</td>
<td>Package instructions</td>
<td>4 X / day</td>
</tr>
<tr>
<td>Dependent / Vent</td>
<td>ICU Suction toothbrush kit (6)</td>
<td>Package instructions</td>
<td>6 X / day</td>
</tr>
<tr>
<td>Dentures</td>
<td>Tools + Cleanser Adhesive</td>
<td>Remove dentures &amp; soak</td>
<td>4X / day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brush gums, mouth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rinse</td>
<td></td>
</tr>
</tbody>
</table>
NV-HAP Incidence
50 % Decrease from Baseline

Control chart for NV-HAP
January 2010 to December 2013

Number of non-ventilator HAP cases
Month/Year
Return on Investment

- 60 NV-HAP avoided Jan 1 – Dec. 31 2013
- $2,400,000 cost avoided
- $117,600 cost increase for supplies
- $2,282,400 return on investment

8 lives saved

PRICELESS
NV-HAP 70% from baseline!

Control chart for non-ventilator HAP
January 2010 to December 2014

- Oral care for all adult pts
- Documentation
- NGT standards revised
- Pharmacy starts PPI protocol
- Started oral care prior to surgery
- Mandatory Education for Nurse Assistants

Number of non-ventilator HAP cases
WHEN WOULD NOW BE A GOOD TIME TO DO THIS?

It is not enough to do your best; you must know what to do, and THEN do your best.

~ W. Edwards Deming
Evidence
Evidence-Based Practice


• It takes as long as 17 years to translate research findings into practice (Balas & Boren, 2000, Managing clinical knowledge for healthcare improvements pp.65-70. Germany: Schattauer Publishing Co.)

• Without current best evidence, practice is rapidly outdated, often to the detriment of patients.
Activity without purpose is the drain of your resources.
Empowered Work Environment

System Role

Education Specialist

Unit Educator

Unit Medical Director

Patient/ & Bedside Family

Clinical Nurse Specialist

Nurse Manager

Inpatient Unit

Unit Governance Council

Nurse Manager System Role

CNS System Role
Patient Safety Strategies Strongly Encouraged for Adoption with Moderate to High Evidence

- Preoperative and anesthesia checklists to prevent perioperative events
- Bundles with a checklist to prevent CLA-BSI
- Interventions to reduce use of urinary catheters; stop orders, reminders or removal protocols
- Bundle to prevent ventilator associated pneumonia
- Hand hygiene
- Multiple component initiative to prevent pressure ulcers
- Prophylaxis intervention for venous thromboembolism
- Using real-time ultrasonography for placement of central catheters

Alspach JG. Crit Care Nurse, 2013;33(3):9-12
Patient Safety Strategies Encouraged for Adoption with Moderate to High Evidence

- Interventions to reduce patient falls
- Using clinical pharmacist to reduce adverse drug events
- Documenting patient preference for life-sustaining treatment
- Obtaining informed consent prior to medical procedures
- Team training
- Medication reconciliation
- Using surgical outcome report cards
- Rapid response systems
- Computerized provider order entry
- Using simulation training and patient safety efforts

Alspach JG. Crit Care Nurse, 2013;33(3):9-12
Using Evidence to Drive Outcomes

What are best practices in your areas that drive safety?
Team
There is no “I” in TEAM…but there is a “ME”
Path to High Performing Teams

- Team Leadership
- Mutual performance monitoring
- Backup behavior
- Adaptability
- Team orientation

- The leader directs & coordinates team activities
- Team members monitor each other's performance
- Team members anticipate & respond to one another's needs
- Team adjust strategies based on new information
- Prioritize team goals over individual goals

Shared Mental Model
Closed Looped Communication
Mutual Trust

Communication Breakdowns Cause Infection-associated Events

Root causes of infection-associated events (2005)

- A. Communication 75%
- B. Environmental Safety/Security 50%
- C. Continuum of Care 39%
- D. Competency or Credentialing 38%
- E. Procedural Compliance 38%
- F. Patient Assessment 25%
- G. Leadership 25%
- H. Staffing 13%
- I. Availability of Information 13%
- J. Orientation and Training 12%
- K. Organizational Culture 12%
Communication Breakdowns Cause Treatment Delays


- Communication: 86%
  - Continuum of Care: 52%
  - Orientation and Training: 41%
  - Availability of Information: 39%
  - Leadership: 19%
  - Staffing: 25%
  - Organizational Culture: 18%
  - Environmental Safety/Security: 19%

- Patient Assessment: 77%
  - Care Planning: 20%
  - Procedural Compliance: 17%
  - Competency and Credentialing: 35%
Tools and Strategies to Improve Communication and Teamwork

• Daily rounds/goals
• Structured Handoff
• Huddles
• Pre-procedure briefing
• Checklists
• Learn from a Defect
Effective Teamwork’s Positive Impact on Health Care

- Reduced length of stay
- Higher patient satisfaction
- Lower nurse turnover
- Higher quality of care
- Greater ability to meet family member needs
- Better patient outcomes
- Better patient experience with care scores

“Even if you are on the right track, you will get run over if you just sit there.”

Will Rogers
It Takes a Village
Tools Don’t Create Safety

People Do!!!

The Silent Treatment, April 2011
The Most Powerful Force of Human Behavior is Social Influence
Accountability is a willingness to answer to results and behavior. It’s a commitment to own, discuss and learn from mistakes and successes in an environment where individual and shared ownership produce outstanding results.

Cox, S. Nursing Management. Sept 2018;25-30
Accountability

Clear Expectations

Follow through

Rewards or Consequences
Yes I Will

Focus on Achieving Excellent Care Outcomes & Commit to a Culture of Safety & Accountability
Yes I Will

Be the Power of One

“I am only one, but still I am one.
I cannot do everything, but still I can do something.
I will not refuse to do the something I can do.”

Helen Keller
“You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do.”

Eleanor Roosevelt
Change and growth take place when a person has risked himself & dares to become involved with experimenting with his own life

Herbert Otto
Yes I Will

Be the Innovation for Creating a Safe Environment for the Patient and the Healthcare Worker
Questions?

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