The Future is Now: Designing Your Practice to Impact Patient Outcomes

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Self
Advocacy
Fundamentals
Evidence
Team
Yes I Will
Self
Number 1 Respected Profession

Nursing
Gallup Poll: 82% Honesty & Ethical Rating

So Why Don’t We Feel Respected?
Reclaiming Professional Respect

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

Work Environment

Quality of Care You Provide to Patient & Families
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
Respect

Self Respect
Self Respect

Internal Dialogue

External Dialogue

Savage Chickens by Doug Savage

YOU'RE NOT GOOD ENOUGH

ALL T.V. COMMERCIALS, PARAPHRASED
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

- Nurses knowledge of the Evidence based care
- Ability to deliver the care to the right patient at the right time, every time it is needed
- The ability to communicate patient 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 for Nursing

- Self Respect
- Communication
- Safety Environment
- Advocacy Teamwork
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

Almost 70% of abuse towards nurses is not reported

Impact Of Factors That May Chip Away at Us

• Horizontal violence/verbal abuse
  – Communication issues are 77% of the reason for errors
  – If we don’t feel respected, we don’t share information/Threatens patient safety
  – One of the major reasons why nurses leave the profession, complaint of burnout or job dissatisfaction, lose capacity for caring

• Poor quality of work environment
  – Low autonomy, missing equipment, insufficient staff, poor design in technology, negative work culture
  – Performing non patient care activities

Gurses AP. Applied Ergonomics, 2008:1-10
Silence Kills, AACN
“Our lives begin to end the day we become silent about things that matter”

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

John Tillotson
Non-Verbal Communication
Speaking Up: Does a Plan Education Program Improve Advocacy

- Quasi-experimental design
- Intervention design to increase speaking up behaviors among nurses in situations were patient safety is in jeopardy
- 2 hospital, same health system
- 51 RN’s control group, 53 in intervention group
- Intervention; remove any sanctions, viewed video from CNO & CMO expressing commitment to back speaking up, discussion of organization obstacles, then individual obstacles, generate a personal action plan, planned peer support
- Results:
  - Significant increase in speaking up behaviors vs. control (p<.0001)

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 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
Structured Handoffs/Clinical Handover

• Information Processing: Making sure the essential data are transferred for patient safety
• Structured face to face, structured tool, electronic sign outs
• Substandard or variable handoffs has contributed to errors, care omissions, treatment delays, inefficiencies from repeated work, inappropriate treatment, adverse events, increase length of stay, voidable readmissions, an increase cost.
• 2013 ACHS NSQHS Standards measure to implement a standardized approach to communication during handoffs

ACHS NSQHE Standards
Bedside Shift to Shift Handoff: Systematic Review of Literature

• Systematic review of the literature from January 1, 2008 to October 31, 2014 - 41 articles meet criteria for inclusion & were reviewed
• Articles eligible for review focus on shift to shift handoff of any healthcare professional
• Bedside handoffs-overall aim
  – Face-to-face interaction
  – Clarification & resolution of erroneous information
  – Introduction of the oncoming nurse
  – Assessment of the patient during handoff

Bedside Shift to Shift Handoff: Systematic Review of Literature

- Results - Structures used
  - 34% contained mnemonic used during shift handoff, SBAR, ISBAR (introduction), SBART (thank you)
  - P-Vital (presenting information, checking patient’s vital signs, checking input and output checking patient’s treatments, discussing admissions or discharge and filling out legal documents)
  - I PASS the BATON: introduction, patient assessment, situation, safety concerns, background, actions, timing, ownership and next
  - ISHAPED: introduce, story, history, assessment, plan, error and dialogue

Bedside Shift to Shift Handoff: Systematic Review of Literature

• Results-
  – Self-reported outcomes: staff and patients
    • Indicated improve satisfaction or perceptions with bedside handoff
    • 10% reported perceived better patient care
    • 2% fewer patient complaints
  – Process outcomes:
    • 15% indicated decreased time spent in handoff
    • 12% decrease overtime hours are related costs
  – Patient outcomes:
    • 15% of the studies assessed patient outcomes
    • Reduction in falls (5 studies)
    • Reduction in clinical incidents
    • Improve patient & staff satisfaction & staff accountability

What to Do Individually?

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

- Assess culture of safety (SAQ & AHRQ)
- Educate staff on science of safety
  http://www.safetyresearch.jhu.edu
- House staff orientation
- Identify defects
- Learn from one defect per quarter
- Assign executive to adopt unit
- Implement team/communication tools
- Reassess culture annually

http://www.onthecusptophai.org/
Healthy Work Culture Standards

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

A healthy culture begins with each person & is enhanced by self work, healthy relationships & system supports
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!

Hospital Variation in Missed Nursing Care

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 2. Elements of Nursing Care by Ability of Patient to Report and Extent Missed*

<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>• 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>
</tr>
<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
- Catheter Care
- Skin Care/Bathing/Mobility

HAND

Patient

HYGIENE

CA-UTI
CLA-BSI
SSI
Falls
HASI

Vollman KM. Australian Crit Care, 2009;22(4): 152-154
Factors Impacting the ability to Achieve Quality Nursing Outcomes at the Point of Care

Vollman
KM. Intensive & Critical Care Nursing, 2013
Oct; 29(5): 250-5
Recognition & Reprimand Structures within Acute Care Settings

- **Recognition**
  - Physiologic assessment
  - Completing medical treatments in a timely fashion
  - Assisting physicians with activities

- **Reprimand**
  - Medication administration
  - Questioning content of medical orders
Behavior that is recognized and reinforced continues

Behavior that is ignored or not reinforced does not continue
Preventing NV-HAP Through Evidence Based Fundamental Nursing Care Strategies

Slides courtesy of Barbara Quinn
Why NV-HAP?: DO NO HARM

- HAP 1st most common HAI in U.S.
  - Increased morbidity → 50% are not discharged back home
  - Increased mortality → 18%-29%
  - Extended LOS → 4-9 days
  - Increased Cost → $28K to $109K
  - 2x likely for readmission <30 day
- Understudied, under-addressed
- Focus has been on the other HAP → 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

SMCS HAP Prevention Plan

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, Brush 1-2 minutes, Rinse</td>
<td>4 X / day</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, Brush gums, mouth, Rinse</td>
<td>4X / day</td>
</tr>
</tbody>
</table>
NV-HAP Incidence
50% Decrease from Baseline
Return on Investment

- 60 NV-HAP avoided Jan 1 – Dec. 31 2013
- $2,400,000 cost avoided
- $2,282,400 return on investment
- 8 lives saved

PRICELESS
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

NV-HAP ▼ 70% from baseline!
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.
Program overview:

Activity without purpose is the drain of your resources
Organizational & Unit Structures that Supported Empowerment & Evidence Based Practice

- Shared Governance Model
- Professional Practice Model/Clinical Ladder
- Unit Based Leadership Model
- Educational Support
- Continuous Quality Improvement Model
Foundational Principles to Maximize Staff Empowerment

- Share Governance = Shared Leadership of Practice/Ownership
- The Unit is the center of a shared governance model...the locus of control is at the point of service
- Staff need mentoring and leadership coaching
- Shared leadership means the clinical and administrative lead of the unit are part of the unit practice/goverance council
- Defined accountability of all members
- Sufficient time in meetings to formulate ideas and plan work (unit meeting 4hrs)
Empowered Work Environment

System Role

Education Specialist

Unit Role

Unit Medical Director

Patient & Family Nurse

Bedside Nurse

Clinical Nurse Specialist

Unit Governance Council

Inpatient Unit

Nurse Manager

Nurse Manager System Role

CNS System Role
We Make a Difference in Quality & Safety

- Increase nurse staffing was associated with: lower hospital related mortality, lower cardiac arrest, lower hospital acquired pneumonia in the surgical population, lower episodes of failure to rescue, lower UTIs, lower G.I. bleed/shock, lower falls & rates in hospital acquired pressure ulcers.
- The risk of hospital deaths would increase by 31% or roughly 20,000 avoidable deaths each year if all hospitals at eight patients per nurse instead of four (JAMA 2002).
- When nurses case managed children with asthma there were fewer absences from school.
- 11% improvement in failure to rescue (HealthGrades 2009 Report).
We Make a Difference in Quality & Safety

• Home care/discharge planning/APRN’s; lower length of stay, lower healthcare costs, fewer hysterectomies
• Patient satisfaction directly correlated to registered nurse satisfaction (HCAHPS)
• 10% ↑ in the # of RNs ↓ lung collapsed by 1.5%, pressure ulcers 2%, Falls 3%, UTI < 1% (Urich Med Care 2003, 41(1):142-152)
• Nurses effect explained 7.9% of variance in patients clinical condition during their hospital stay (Yakusheva O, et al, HSR, 2014)
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

- Food Service
- Supply Chain
- Social Work
- Admitting
- Discharge
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

Tools and Strategies to Improve Communication and Teamwork

• Structured Handoff
• Huddles
• Daily rounds/goals
• Pre-procedure briefing
• Checklists
Learn from a Defect Tool

- Designed to rigorously analyze the various components and conditions that contributed to an adverse event and is likely to be successful in the elimination of future occurrences.
- Tool can serve to organize factors that may have contributed to the defect and provides a logical approach to breaking down faulty system issues.

### Huddle Issues Requiring In-Depth Review Gets the Full Drill Down

<table>
<thead>
<tr>
<th>Contributing Factors (Exs)</th>
<th>Factors that contributed to incident</th>
<th>Factors that helped prevent or limit harm</th>
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1. **What happened?** (Reconstruct the timeline and explain what happened. For this investigation, put yourself in the place of those involved. In the middle of the event or at the unfolding of the incident, what were the actions and the reasoning behind their actions/decisions? Try to re-create what they did when the event occurred.)

2. **Why did it happen?** Below is a framework to help you review and evaluate your case. Please read each contributing factor and decide whether it was involved. If so, did it negatively contribute (increase harm) or positively contribute (reduce impact of harm) to the incident. Rate the most important contributing factors that relate to this event.

- **Contributing Factors:**
  - Patient Factors
  - Task Factors
  - Cognitive Factors
  - Team Factors

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**Patient Factors:**
- Patient was acutely ill, confused, obtunded, incoherent, post surgery (drowsy, incoherent)
- There was a language barrier (Patient is English/English)
- There were personal or social issues (Patient had a hearing problem)

**Task Factors:**
- Why is care of available to guide therapy? (Monitors for ongoing medication changes to avoid the medication error)
- Were lab results available to help make care decisions? (Lab blood glucose results available to nurses)
- Were lab results accurate? (Phenobarbital was noted, but daflin was related quickly to nursing)
Saint Joseph Mercy Health System
Daily Huddle Process

The purpose of daily huddles is to help to facilitate safe, effective and efficient patient care. SJMH has developed this process to align the organization’s overall strategic goals with unit based team goals, and the day to day activities of staff. This empowers all staff to have an impact on positive change leading to remarkable care.

To accomplish such an alignment, unit based teams will choose 3 metrics that align to key objectives for SJMH. These objectives are:

- Quality/Safety
- Patient Satisfaction
- Operational Performance

In choosing the metrics, the unit based team will collaborate with the unit staff to identify and track the metrics. These metrics should represent areas identified in the unit team dashboard and/or other improvement opportunities that align with the hospital key objectives. The team will complete the accompanying Huddle Metrics Selection form, documenting the proposed metrics and rationale for selection.

The unit will communicate progress on the 3 key metrics using the standardized Huddle Board. This board will be reviewed by all staff on the unit each shift, daily, as part of the Huddle Process. In addition, the team will analyze trends in metrics and identify opportunities for improvement.

Once a metric has achieved the target goal and shown sustainability (typically for 3 to 6 months), then it should be removed from the Huddle Board and replaced with another metric proposed by the team and unit staff.

Metrics Don’t Change Until You Have Been Successful
Huddle - Process Definition

The purpose of daily huddles is to help to facilitate safe, effective and efficient patient care. SJMH has developed this process to align the organization’s overall strategic goals with unit based team goals, and the day to day activities of staff. This empowers all staff to have an impact on positive change leading to remarkable care.

The huddle process will include:
- Brief mandatory team huddle with all unit personnel
- Review of specific unit QI metrics
- Ideas in Motion: Capturing opportunities for immediate action and/or improvement.

Huddles are to be conducted each shift, at the assigned time, and with all associates within a 15 minute time frame. The agenda will regularly focus on the 3 metrics chosen by the unit for quality/performance improvement.

Manager:
- Ensure the huddles are being conducted each shift following the standardized Huddle Agenda. The Manager can conduct the huddle(s) or assign a huddle leader (for example a CNS, unit practice council member, CNL or charge nurse) to conduct the huddles.
- Will assign an individual to update the metric information board prior to daily shift huddles (for example the unit clerk, CNL or charge nurse)
- Ensure follow-up and feedback is provided in the huddle on environment or equipment issues identified on prior days. (Examples may include, missing tele packs, Broken IV pumps, lack of laundry, tele pagers, etc.)

Huddle Leader (Manager or Designee):
- Obtain all information necessary for leading a successful huddle at least 15 minutes prior to the huddle start.
- Lead the huddle following the standardized Huddle Agenda.
- Maintain attendance log (or assign someone to take attendance)

Staff:
- Huddle attendance is mandatory on each shift at the designated time.
- Staff who cannot attend a shift huddle due to unavoidable issues will review the huddle board and meet with manager or designee to discuss missed information and reason for missing huddle.
Hospitals With High Teamwork Ratings

- Higher patient satisfaction
- Higher nurse retention rates
- Lower hospital costs

“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
“Setting an Example is Not the Main Means of Influencing Others….It is the Only Means”

Albert Einstein
Yes I Will

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 Nurse Sensitive 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
Questions?

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