Turning Quality Upside Down: Using a Perfect Storm to Change the Quality Performance Culture

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Session C501
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Centura Health

- A faith-based, nonprofit health care organization formed in 1996 by Catholic Health Initiatives and Adventist Health System
- Colorado's fourth largest private employer with nearly 13,000 associates
- The Centura system encompasses 12 hospitals, seven senior living communities, and Centura Health at Home – home care, hospice, infusion, home medical equipment and oxygen services
Porter Adventist Hospital

- Acute Care Hospital
- Cancer Care Center
- Center for Joint Replacement
- Craniofacial & Skull Base Disorders
- Complex Medicine
- Heart Institute
- Centura Health Transplant Program
- Robotics Institute
- Spine Institute
- 368 licensed beds with 1450 associates
- Magnet designation – January 12, 2009

Sharon Pappas, RN, PhD, NEA-BC
Chief Nursing Officer- Porter Adventist
Chief Nursing Executive -Centura

Objectives

- Identify vulnerabilities, “perfect” performance and adherence to regulations and policies across the care continuum.
- Discuss steps in developing culture, change supporting individual professional accountability and healthcare system performance.

What to Expect

- How Blood changed an organization
  - Background
  - Story
  - Quality Tools
  - Lessons Learned
  - Where We are now
Evidentiary Background

- AHRQ (2009) – The number of hospital stays for patients who received blood transfusions more than doubled between 1997 and 2007. (from 1.1 million to nearly 2.7 million)
- Blood Administration is a High Risk Procedure.

Regulatory Background

- CMS: A-0409 § 482.23(c)(3): Blood transfusions... must be administered in accordance with State law, personnel must have special training.
- TJC: HR.01.02.01: Define staff qualifications. If blood transfusions ... are administered by staff other than doctors of medicine... staff members must have special training.
- State of Colorado Licensure Standards

Story of a Culture of Assumption

- Education
- Audits at a high level (ORR)
- Good is Good enough
- Triggers
A Perfect Storm

“A perfect storm is a convergence of independent events that form an environment never experienced before”. (Fields, 2006)

A Culture of Low Expectation

Three prevailing winds or barriers to exemplary blood and blood product administration practice,

• “failure to see,”
• “failure to move,”
• “failure to finish”

converged to create the perfect storm that threatened our culture of excellence

(Black & Gregersen, 2008; Kerfoot, 2010)

Perfect Care Implementation Timeline

[Diagram showing implementation timeline with phases such as Baseline Data Collection, Literature Review, EBP (Iowa Model), SOC Evaluation, just culture & peer review, etc.]

Starting the Transformation

- Massive Education & Competency Validation
- 402 Registered Nurses / 6 Weeks

Developing the Audit Tool

- Audits
  - EMR
  - Area Specific
  - Policy
  - Defining Failure

Audit Expectations

- Audits
  - 100%
  - Concurrent
  - Inpatient
  - Outpatient
  - Facility RNs Only
  - Nursing Leader Champion
**Failure to See**

*"We do a great job……"

- Validating Assumptions
  - Targeted Audits
  - Education
  - Competency

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**Failure to See**

- Targeted Audits

*Every Unit, Every Blood Product, Every Week*

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**Failure to See**

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Failure to See

Vital Signs = 72% of Failures

Source of Failures Week 1-8

<table>
<thead>
<tr>
<th>Cause</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs</td>
<td>Policy has specific Temperature – 37.5</td>
</tr>
<tr>
<td></td>
<td>Policy allows for 30 minute VS (with blood infused under 30 minutes)</td>
</tr>
<tr>
<td></td>
<td>Vital Signs being delegated to CNA</td>
</tr>
<tr>
<td></td>
<td>Patient moving to other location before 15 minute VS</td>
</tr>
</tbody>
</table>

“We don’t do as great a job as we thought...”

• Cause and Effect Analysis
  • Vital Signs
    • Policy has specific Temperature – 37.5
    • Policy allows for 30 minute VS (with blood infused under 30 minutes)
    • Vital Signs being delegated to CNA
    • Patient moving to other location before 15 minute VS

“How good do we need to be?.....”

• Ongoing Dialogue
  • Identify goal of 100% compliance with policy
  • Communicate expectations to leadership and staff

“Is perfection achievable?.........”
Failure to Move

“It's time for an overhaul…”

Responding with Action

• Just-In-Time Training
  • TAR with
    • Competency Validation
  • Update Policy
• Just Culture
• Peer Review
• Taskforces

Updated Policy

• Focus on EBP
  • Our Failure Points
  • Literature Search
  • Professional Organizations

Supporting Culture Change

• Changing the Culture
  • No delegation of Blood Vital Signs
  • No transport of patient before 15 minute Vital Signs
  • Standardize - all Blood has 15 minute Vital Signs
  • Remove specific temperature to allow for nursing judgment
Trigger for Action

Monitor for Success
Move the Culture

• **Triggers of Failures = PDCA**
• Rapid Decision Making Team September 23rd
• Change started September 30th

Failure to Finish

“Why can’t we get this right?.....”

• Analyze Failures
  • System
  • Behavior
• No Fail Deadline
Failure to Finish

“Why can’t we get this right?.....”

• Just Culture Environment
  • Concurrent Coaching
  • Peer Review
  • All levels
  • Audits

Just Culture Algorithm

Failure to Finish

“Are these system or behavior?...”

Failure Tracking Identification
June 2010-December 2010

- Consent, 1%
- Start/Stop, 20%
- VS - Pre, 32%
- VS - Post, 35%
- VS - 15 min, 29%
- VS - 15 min, 29%
- VS - Post, 26%

38 Failures in 50,122 data points
Failure to Finish

“I think we did it…….”

- Audit Cycle
  - Weekly audits
  - Cause and Effect
  - Just Culture on Every Failure
  - Re-educate as needed
  - Ownership

(Patel, 2010)

Celebrating Success

- “Bloody Good Job”
- Red Velvet Cakes

Sustaining the Gain

- No Fall Environment
- Week 18: ongoing

Establish ongoing Audit Plan
Analyze Failure for Systems: Behaviors

Perfect Blood Administration
Week 18
Ongoing Audit Plans

Failure to Finish

“Are these system or behavior?...”

Sustaining the Gain
Surviving the Storm

A Closer Look at Quality

System Failures PDCAs
- Recognition of Transfusion Reactions
- Consents
- Vitals Signs
- Non-Facility Associates

Data is Key to Changing Practices

- Just Culture identified individual accountability and system issues
- Data identified improvement opportunities
- Focused on reducing variability

Improvements:
1. Just Culture analysis for each failure
2. Enhanced policy distributed
3. Changes to consent process, TAR in EHR
Key QAPI Lessons

- Ensure execution throughout PDCA
- Measure performance (i.e., compliance) at the policy element level
- Objective approach to change management
  - Agreement on target performance
  - Data on performance
  - Just Culture analysis when there were misses
- Leadership from Executives to Charge Nurse

Translation to Other Indicators

- Care Plans
  - Critical Values
  - Restraints

Cultural Shift

*Culture of Education and Validation with Verification*

- “How are we going to measure this?”
- “How will we know if this works?”
- “We are not going back to the old way…”
- “This is about professional accountability for my practice.”
- “We are all accountable for patient safety”
- “I have a question…..”
Where are we Now?

• A “Vision of Excellence” practice environment was achieved.

• A “perfect storm” environment brought about redesign of leadership roles, performance measures and professional accountability.

• Utilization of a targeted audit cycle led to a no-fail practice culture.

Translation to Other Facilities

• Independent Auditor Validation
  • Selected as a Best Practice for Quality
  • Process adopted throughout 13 other hospitals within the system

Questions?

“Success is the ability to go from failure to failure with no loss of enthusiasm.”

Winston S. Churchill

(Secretan, 1999)
References