



Creating a Culture
of Quality

CREATING A CULTURE OF QUALITY: Developing the Infrastructure to Meet Quality Improvement Requirements

Developing a sustainable culture of
quality & dealing with recidivists

Peter B. DeOreo, MD, FACP
Centers for Dialysis Care
Cleveland, OH
pbd@cdcare.org



Quality Care

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Kathleen N.Lohr
A Strategy for Quality Assurance
Institute of Medicine, 1990

Culture of Quality

System of Care that enables Quality Care

- Keeps the patient at the center of decision making
- Clear, simple, and consistent P&P
- Universal accountability toward adherence
- Leading indicators of critical processes apparent to the “owners” of the process
- Data driven improvement cycles
- Open and respectful communication among and between *all levels* of the care team

Quality Care _{not}

- Gap between expected and observed outcome
- What should have happen did not happen
- Often, Frequently, Usually, Always [pick your choice]
- Attributed to [blamed on] the mistake, error, or poor performance

• →

re·cid·i·vist  *noun* \-vist\
Definition of RECIDIVIST

: one who relapses; *specifically* : a habitual criminal

– **recidivist** *adjective*

– **re·cid·i·vis·tic**  *adjective*



The “Blame Trap”

Blame is universal, natural, emotionally satisfying, and legally convenient. *It does nothing to make health care safer.*

-- Reason, 1994

Safety/Quality Conundrum

- Medical workers are expected to function without error.
- Errors are made by highly competent, careful and conscientious people for the simple reason that everyone makes mistakes every day.

Lucian Leape, 1997

... but the effective remedy is not to browbeat the health care work force by asking them to *try harder* to give safe care.

Poor designs set the workforce up to fail, regardless of how hard they try...

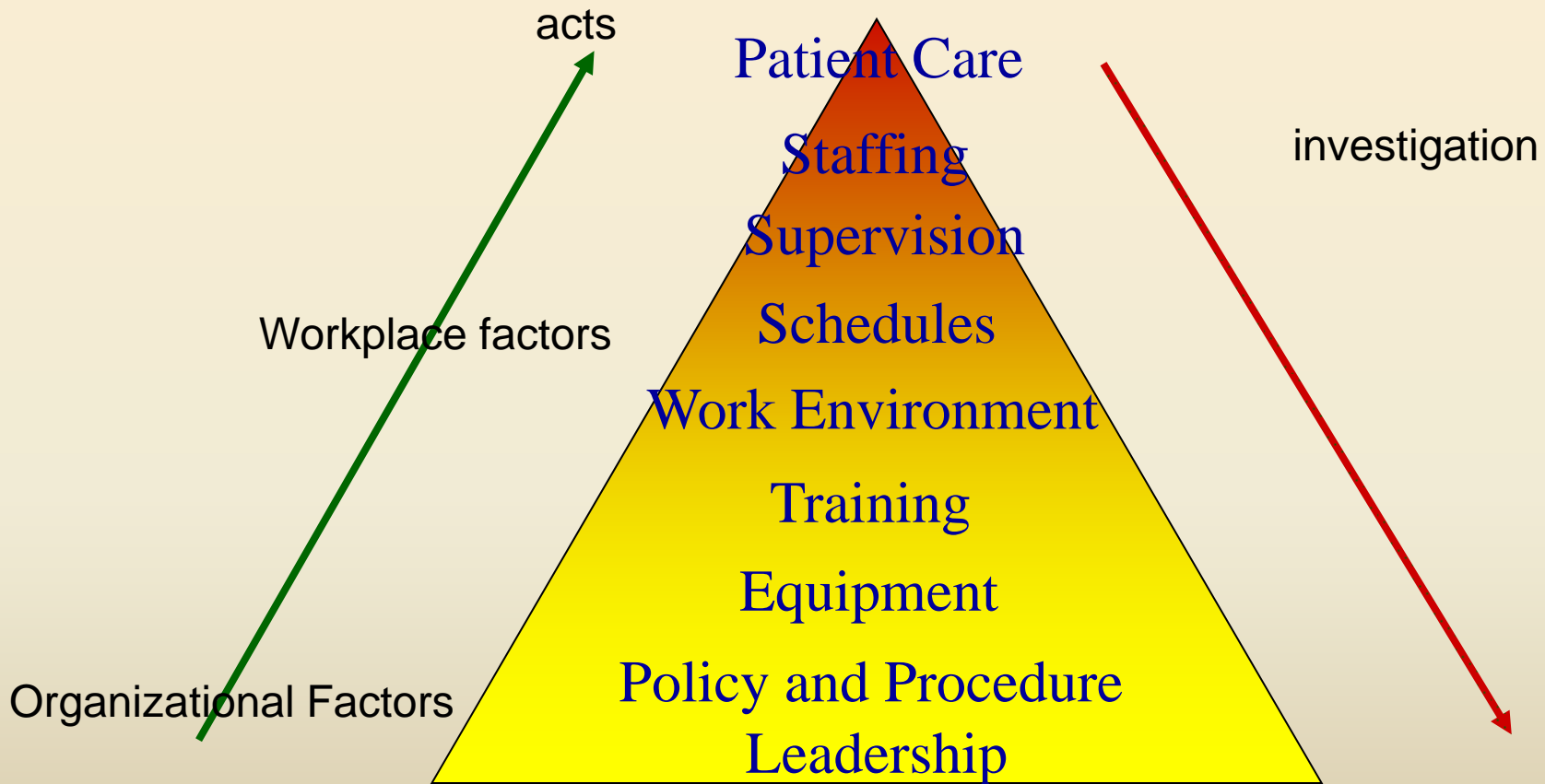
Crossing the Quality Chasm
National Academy Press, 2001

Quality is a system property

1. Safe – avoiding injury
2. Effective – evidence based
3. Patient Centered – respectful and responsive to individual
4. Timely – reducing waits and harmful delays
5. Efficient – avoids waste
6. Equitable – eliminates disparities of care

Crossing the Quality Chasm: a new health system for the 21st Century / Committee on Quality Health Care in America, Institute of Medicine
National Academy Press, Washington, DC, 2001

Systems Have a Blunt and a Sharp End



Facts about Systems

When placed in the same system, people, however different, tend to produce similar results. -- Peter Senge

Every system is perfectly designed to get exactly the results it gets. -- Donald Berwick

If you do what you always do, you'll get what you've always got. -- W. Edwards Deming

Culture is a System Property

3/16/2011

A renal community collaboration



To Change a Culture

- Understand elements of human performance
- Understand what influences behavior
- Balance “no blame” with “accountability”
- Balance “no blame” with “just workplace”
- Demand open and respectful communication among and between all members of the team
- Demand visible and effective leadership from the Medical Director

To change the culture

- Change the system
- Change the reward structure
- Exploit the factors that influence behavior
- To change the outcomes of care, change the behavior (process of care) that supports the desired outcome.

Human Performance

after Rasmussen

- Skills feed forward
 routine → Programmed schema
- Rules feed forward
 trained for → “If --> Then”
- Knowledge feed back
 trial and error → Synthetic thought

Performance and Error Type

Performance Level

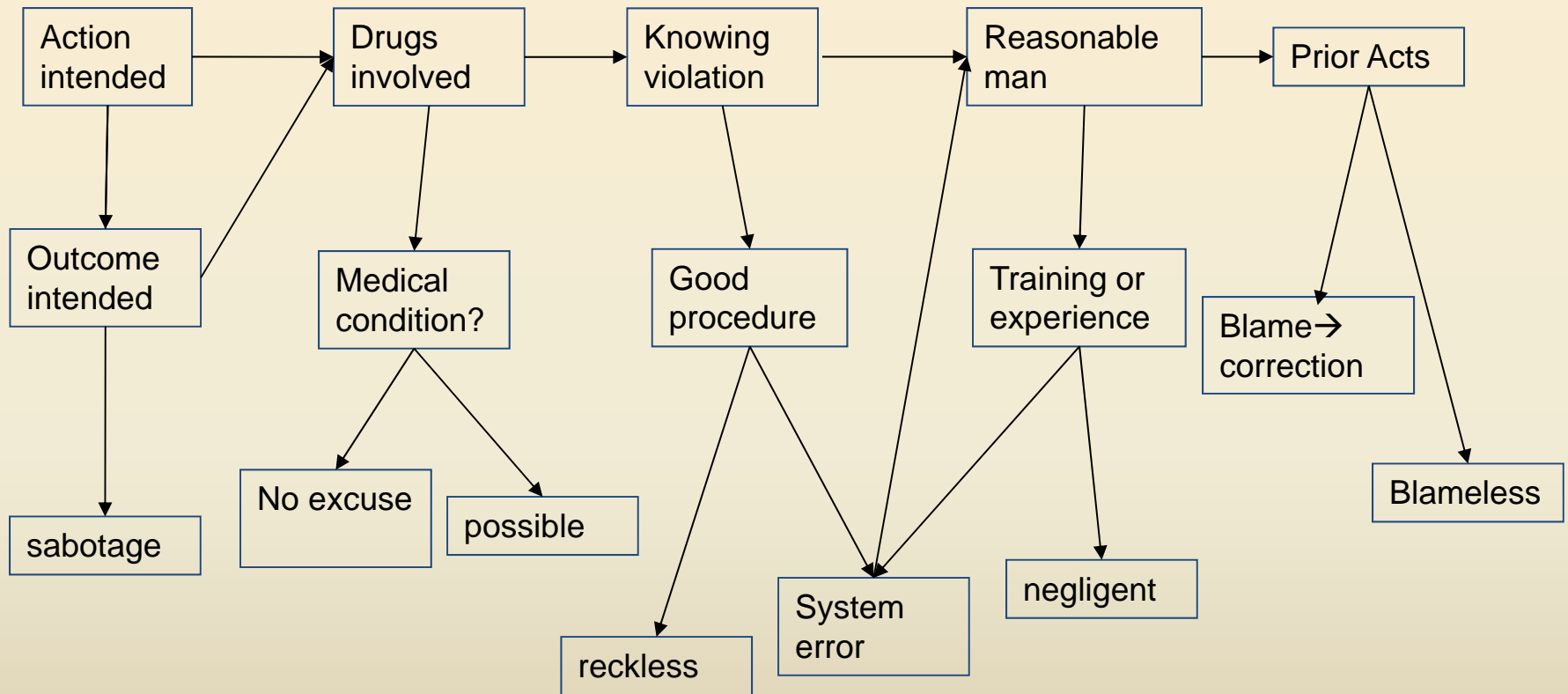
- Skill based
- Rule based
- Knowledge based

Error Type

- Slips and Lapses
 - Inattention
 - Over attention
- RB mistakes
 - Good Rules
 - Bad Rules
 - Too few rules
- KB mistakes
 - Bias
 - Cognitive Strain

Assigning Blame

(holding accountable)



James Reason



How to change behavior

- If your explanation for all poor performance is the employee is “lazy” and “stupid”
 - You assume an unfixable condition.
 - Your interventions are limited.
 - Your success will be limited.
 - You have to explain who hired and trained all these lazy and stupid people.
- If they weren't lazy and stupid when you hired them, what about working for you makes them lazy and stupid?

Changing Behavior

Traditional

- Charisma
- Power
- Perks

Limitations

- Not necessary
- “dispositional” vs “situational”
- Kills relationship (win/loss)
- Inspires resistance
- Transient
- May demotivate
- Makes satisfaction external

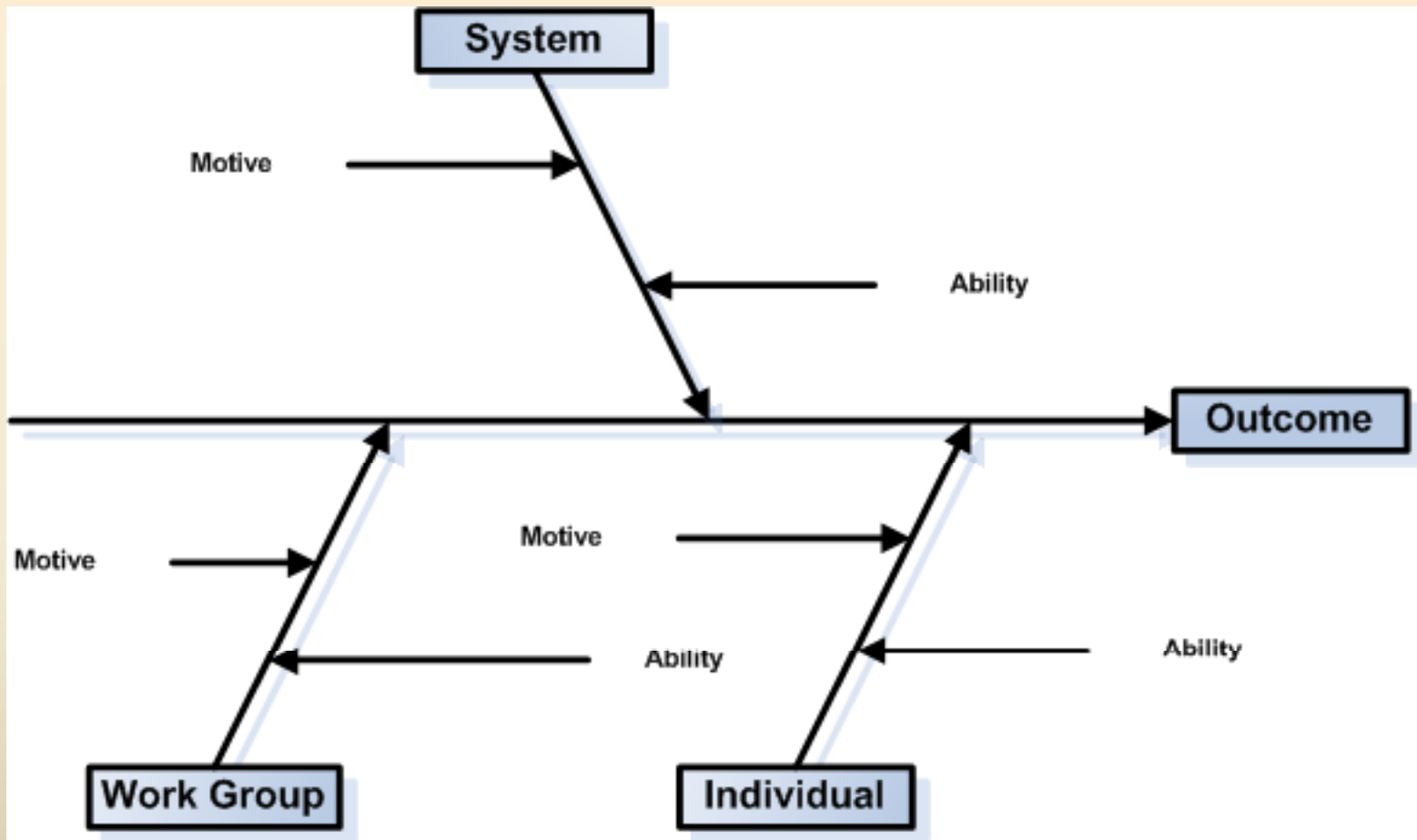
Patterson et. al.: Crucial Confrontations
McGraw-Hill, New York, 2005

Six Sources of Influence

Locus	Motivation	Ability
Personal (me) (values)	Pain & Pleasure Undesirable → desirable	Strength & Weakness
Social (us, others) (culture)	Praise & Pressure Harness Peer Pressure	Help & Hindrance Social Capital
Structure (them, things, space) (mission)	Carrots & Sticks Design rewards Demand accountability	Bridges & Barriers Change the Environment

Patterson et. al.: Influencer
McGraw-Hill, New York, 2008

Another way to look at Root Cause Analysis



Illustrative Examples

- Staff Turnover
- Enhancing RN leadership
- HD Outcomes
 - Kt/V
 - Dry Weight
- QAPI process
- Allergy to Vancomycin

Staff Turnover

- New Hires (RN's and Patient Care Techs)
- Exit Interview, Surveys, Focus Groups
 - Practice different than P&P and training
 - Emphasis on speed, short cuts “encouraged”
 - Schedule not followed creating time conflicts
 - Hazing and Intimidation
 - RN's afraid of retribution if hold Techs accountable
 - Patient's inappropriate comments and behavior

Locus	Motivation	Ability
Personal	“go along” easier	Not able to stand up Not aware that not acceptable Didn’t recognize as bullying
Social	Peer pressure contrary to P&P Emphasis on Speed Got to “suck it up” to work here	My patient your patient, no “our patient”
Structure	No consistent accountability to P&P or schedule adherence No zero tolerance on bullying	Schedule not efficient No consistent Response to patient intimidation 4 hr pt only 3.5 hr slots

Workplace Bullying

...repeated inappropriate behavior direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others ... undermining the individual's right to dignity at work.

Task force on the Prevention of Workplace Bullying (2001)

Workplace bullying

- 35% of American Workers have experienced bullying firsthand.
- 75% of the time, the target of the bullying behavior leaves the company rather than resolves the issue.
- Turnover attributed to verbal abuse: 24% for staff nurses, 25% for nurse managers.

Response

- Company wide education on bullying
 - Staff do not have to “suck it up” from their peers or patients
- Role playing exercises
- Clear definitions
- Required Behavior
 - Hold each other to respectful communication
 - Report all incidents
- Clarify and apply consequences
 - Patients included in the education program
- Identification of patients with behavior issues
 - care plans (HCTA).
- Adoption of computerized scheduling
 - Only supervisors can alter or change schedule
 - Patients not allowed to come into treatment area before called

Enhancing RN Leadership

- Multiple Decisions resulted in RN's being out of the treatment area
 - Removal of Med Cart took RN to central nursing station to draw up meds
 - No outside line in treatment area takes RN to central nursing area to page and respond to MD's
 - Computerization of Care Plan forces RN's to compete with Techs for treatment area computers
 - Techs prefer computers on center desk to chairside
 - No need for gloves, Can sit more easily
- RN absence undermines Nursing credibility

Locus	Motivation	Ability
Personal	Conflicting expectations	Adherence to Med P&P Care Plan completion
Social	Detrimental to RN credibility	Competition for the work space as the center desk
Structure	Administration slow to respond to RN concerns Task completion more important than professional growth	Design of treatment areas did not keep RN visible and engaged in the conduct of the treatment

Response

- Dedicated line “red phone” for MD~RN communication.
- Clarification of work area priorities.
- Training techs to use the height adjustment on computer carts allowing them to sit at the chair-side with the patient
- New, compliant medication preparation area at center desk.

HD Outcomes

- \$ Reward for facility Kt/V achievement
- Monthly reporting of % pts off at ≥ 0.5 KG over dry weight
- Noted
 - Treatments shortened significantly less frequently on blood day
 - Practice of turning blood flow up 50 ml/min on every one on blood day
 - Blood flow more likely to be at or above prescribed flow on blood day
 - Number of patients with increase in dry weight
 - Number of patients 0.4 KG over dry wt.

Locus	Motivation	Ability
Personal	Adherence to MD rx not pre-eminent	Adequacy not apparent during the treatment Only measured once a month
Social	Primacy on moving through the schedule No stigma from inconsistent care	Schedule conflicts
Structure	Company rewards <u>outcome</u> not the process (behavior) that supports the outcome	Dialysis adequacy measured only 1/13 treatments though technology allows surrogates on every treatment

Response

- In addition to Time Out “check list”
- RNTL and PCT “shift report”
 - Behavior → increased communication and collaboration with RN and PCT at the beginning of the treatment
 - Review of Previous treatment
 - Review of today’s goals
 - Review of active issues in IDT care plan
- Identification of issues to be reviewed with MD
 - Behavior → increased communication and collaboration with MD and RN
 - MD “visit request” utility in EMR
 - RN and MD “check in” at beginning of MD rounds (or round together)
- Use of On Line Clearance Kt/V
- Tracking of Kt/V and Dry weight on a per treatment basis
- Care team QAPI project (QAPI to the chair side)

Cumbersome QAPI process

- Time spent in data aggregation overwhelmed team
- More time spent in clerical than analytical tasks
- MD perceived as not involved
 - Delayed and cancelled meetings
 - Distracted by beepers and cell phone

Locus	Motivation	Ability
Personal	Task tedious, time consuming and meaningless	Formal, path of least resistance
Social	Most complained about it	Shared suffering Not “endorsed” by Med Dir
Structure	Failure to hold Med Director accountable	Failure to integrate data systems Data tables mixed with notes requiring mindless recopying

Response

- Conversation with Medical Director
 - Review 6 sources of influence on his/her behavior
 - Priority
 - Natural Consequences of feckless leadership
- QAPI meetings scheduled fixed and published
 - Things scheduled *around* QAPI
- IT integrated data systems so reports “auto-populate” and “evaluate” values, identify trends.

Vancomycin Allergy

- RN reports apparent skin infection in 82 y/o, frail woman with ischemic cardiomyopathy to APN.
- APN orders Vancomycin over phone, read back confirms.
- RN records order in EMR.
- Medication administered per protocol. 15 to 20 min later patient has hypotensive reaction and cardiac arrest. Patient DOA to local EW.
- Post arrest review, RN notes that Vancomycin allergy recorded in allergy list, dialysis treatment sheet (RN pre-assessment), and med list.
- RN reports her error to supervisor and risk manager.
- Investigation shows that Vanco allergy poorly documented, with previous harmless administration.
- Patient has had hemodynamic instability on HD with profound hypotension.
- Attending physician concludes medication “allergy” not causally related to arrest.

Locus	Motivation	Ability
Personal	Self reported, clearly wanted to do right thing	No prior acts slip/lapse Inattention Allergy noted 6 places in record
Social	Blaming for error	Relied on senior clinician To her detriment
Structure	Naïve about blame/accountability	No automatic interaction checking in EMR New EMR

Response

- Step 1 corrective action to RN
 - Mitigated because of self reporting
 - Required to take self study medication safety CEU
- APN (medical staff) suspended from authority to give medication pending
 - Review of hospital record to document credibility of allergy
 - Required to take self study medication safety CEU
- Collaboration with EMR provider to add interactions to allergy utility
- System wide webinar to review the documentation requirements in the EMR
- System wide review allergy documentation

Dialysis Practices That Distinguish Facilities with Below- *versus* Above-Expected Mortality

Results: Dialysis facilities with below-expected mortality reported that patients in their unit were more activated and engaged, physician communication and interpersonal relationships were stronger, dieticians were more resourceful and knowledgeable, and overall coordination and staff management were superior *versus* facilities with above-expected mortality.

- Patients more *activated* and *engaged*
- Physician communication was stronger
- The IDT was more responsive, involved, and proactive
- Interpersonal relationships were stronger
- Dieticians were more resourceful and knowledgeable
- Coordination and staff management were superior

Brennan Spiegel,^{*†‡} Roger Bolus,^{†‡} Amar A. Desai,^{§||} Philip Zagar,[¶] Tom Parker,^{**}
John Moran,^{††} Matthew D. Solomon,^{‡||} Osman Khawar,[†] Matthew Gitlin,^{‡‡} Jennifer Talley,^{*†}
and Allen Nissenson^{§§}

Clin J Am Soc Nephrol 5: 2024–2033, 2010. doi: 10.2215/CJN.01620210

Top performing facilities

...[have a] more staff-oriented and friendly environment marked by better perceived staffing, a more communal and **respectful** work place, and a stronger **emphasis on quality educational programs**. This suggests that dialysis managers should aim to formally identify and **correct non-adherence with interpersonal and attitudinal best practices**....

Nissenson, *op. cit.* p 2030

What did we say (hear) today?

- “There’s those that have and those that will.”
- Only *bad* pilots crash, and I’m a *good pilot*
- There are *ALWAYS* behaviors that leaders can take to improve their performance and influence
- Persistence in a low performing status usually points to operational issues beyond content issues
- Need to state specific desirable behaviors to correct measured deficiencies
- Nurse Managers need mentoring
- Sit and Watch

And more ...

- Why, Why, Why, Why, Why ...
- If the manager doesn't feel competent/ confident, what are the patients feeling?
- The tone is set at the top
- Focused discipline
- Explore the backstory
- Visibility of leadership
- Culture change ... "it's somebody else's job"
- It has to be safe for people to tell us there are problems
- Simple recognition can be a powerful motivator

And Finally

Thank you for a job well done