Speakers

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Disclosures

Karen Harris, MD, MPH, FACOG has no real or perceived conflicts of interest to disclose.

John Keats, MD, CPE, FACOG, FACPE has no real or perceived conflicts of interest to disclose.

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Objectives

- Review the barriers to change that organizations may face when attempting to implement patient safety projects.

- Provide tips for improving leadership, teamwork, and communication to overcome barriers and improve the safety culture; tips will be provided from administrative, nursing, and physician perspectives.

- Review various tools that an organization can utilize to improve culture and drive change.
Nursing Response to Quality Initiatives
Accelerating the Adoption of a Safety Culture

• What is needed to make culture change?
  – Senior Leadership

• Research shows 75 to 80 percent of initiatives requiring behavior change fail because leaders are not engaged and actively involved.
Efforts to Drive Change

• Making safety rounds
• Initiating daily safety huddles
• Participating in continuous quality improvement meetings
• Speaking directly with patients and staff members
• Developing recognition programs for individuals who performs well
Data Collection

• Use data to pinpoint opportunities to improve patient safety within the organization
• It helps to identify areas that may need improvement
• Review data regularly for outcomes so that improvements or accolades can be made promptly
• Share data with all healthcare providers
Setting the Pace for Sustained Improvement

• Maintaining momentum
• Openly discuss success and areas that need improvement
• Celebrate success
• Nurses need to be involved in driving their change
Our Journey to Culture Change

Baby Friendly Journey

Phase 3

AWHONN PPH project

18 month collaborative

IHI Safety Bundle

Began in 2010
Oxytocin
Tachysytole
3-4 degree lacerations
Baby Friendly Journey

EDUCATE

MOTIVATE

ADVERTISE

EXPLAIN WHY
Culture Change is a Process

• Writing grants for financial support
• Gain physician support
• Training – educational modules for nurses
• Develop written policies and procedures
• Data collection
• EMR build
• Continued visits to physician providers
• Champion meetings
Culture Change is a Process

- Needs assessments
  - Assessing staffing concerns
- Staff training
- Clinical competencies
  - Instructional method
    - In-person training
    - Computer based
    - Paper based
    - Articles
    - On-line DVD
- Competency attainment
- Orientation procedures
- Training verification
Countries with the Lowest Maternal Mortality Ratios

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AWHONN PPH Project Goals

• Goal 1: Promote equal access of evidence – based care practices
• Goal 2: support effective implementation strategies and tactics to improve clinician practice

  Recognition – Readiness – Response

• Goal 3: Identify facilitators and barriers to making improvements and disseminate lessons learned
AWHONN PPH Project

- Explained Why
- Gradual change process
- Requested Physician leads
- KICK OFF
- Went to OB Department meetings to request participation
Remember Teamwork and Collaboration

Each and every member of the healthcare team plays a role in making a culture change!
Physician Response to Quality Initiatives
Florida Perinatal Quality Collaborative Obstetric Hemorrhage Initiative

• Obstetric hemorrhage is a leading cause of maternal mortality in Florida

• Objective: Improved outcomes in morbidity and mortality related to obstetric hemorrhage, including hysterectomies and massive transfusions

• Meets new national guidelines for OB patient safety
Key OHI QI Elements

**Readiness**
- Develop an Obstetric Hemorrhage Protocol
- Develop a Massive Transfusion Protocol
- Construct an OB Hemorrhage Cart
- Ensure Availability of Medications and Equipment

**Recognition**
- Antepartum Risk Assessment
- Quantification of Blood Loss
- Active Management of the Third Stage of Labor

**Response**
- Perform Interdisciplinary Hemorrhage Drills
- Debrief after OB Hemorrhage Events
OHI

- 31 Florida hospitals and 4 North Carolina hospitals
  - 18-24 month initiative

- Hospital applicant data indicated improvement needed
  - Assessment of risk for OB hemorrhage upon hospital admission
  - Quantification of blood loss
All Initiative Hospitals
Risk Assessment on Admission
Percent of Women that were assessed for risk of Obstetric Hemorrhage at birth admission (chart audit)

Assessment for Risk of Obstetric Hemorrhage (chart audit)

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent achieved through December 2014</th>
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<tbody>
<tr>
<td>Baseline</td>
<td>14%</td>
</tr>
<tr>
<td>December</td>
<td>35%</td>
</tr>
<tr>
<td>January</td>
<td>45%</td>
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<tr>
<td>February</td>
<td>55%</td>
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<td>March</td>
<td>60%</td>
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<td>October</td>
<td>77%</td>
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<tr>
<td>November</td>
<td>78%</td>
</tr>
<tr>
<td>December</td>
<td>75%</td>
</tr>
</tbody>
</table>
All Initiative Hospitals
Quantification of Blood Loss
Vaginal Deliveries: Percent of women in which blood loss was quantified (chart audit)

Quantification in Vaginal Deliveries (chart audit)

Percent achieved through December 2014

Month

- Baseline
  - December: 4%
  - January: 8%
  - February: 9%
  - March: 14%
  - April: 21%
  - May: 22%
  - June: 32%
  - July: 38%
  - August: 44%
  - September: 50%
  - October: 45%
  - November: 44%
  - December: 40%
## OHI Program Evaluation

**Qualitative Interviews n=50**

### Factors Influencing Implementation of the OHI

<table>
<thead>
<tr>
<th>Level</th>
<th>Range of Factors</th>
</tr>
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</table>
| Intervention Factors | • Strength of the evidence for OHI  
                  | • Complexity of implementing the initiative  
                  | • Adaptability of the intervention to local hospital settings  
                  | • Packaging of OHI materials provided by the FPQC |
| Process     | • Engaging people with OHI (e.g., staff; leadership)  
                  | • Planning for the implementation  
                  | • Reflecting and evaluating on the implementation of the OHI |
| Internal    | • Knowledge and beliefs of hospital staff about the OHI  
                  | • Communication within the hospital  
                  | • Available resources provided by each hospital  
                  | • Hospital culture  
                  | • Physician resistance |
| External    | • Degree of contact and networking with other hospitals |
Overcoming Physician Resistance

• Find a physician champion at the outset
• Engage physicians starting at the first planning meeting
• Emphasize the strength of evidence
• Realize for some physicians change is difficult
• Problem of QBL – don’t believe it can be done at a delivery
• Individualize to your hospital setting, but standardize the response
C-Suite Leadership Response to Quality Initiatives
Safety and Culture

• Organizational Culture
  – The interaction between what people think is important and how things work to yield the way we do things around here

• Key is what people think is important
  – Responsibility of leadership
  – No change without culture change
  – No culture change without administrative support
  – Dyad model (physician/administrator) is highly effective
Leadership Commitment

• **Is patient safety the highest priority of the organization?**
  – Is there a patient safety committee of your board?
  – Is there a monthly dashboard of safety indicators?
    • Is it reviewed at every board meeting?
    • Is it the first order of business?
  – Are safety surveys of nurses and physicians conducted on a regular basis?
  – Is there a patient safety officer or safety nurse in place?
Resources

• Will the board commit resources to the safety initiative?
  – If not, can you demonstrate return on investment?
    • Medical liability costs
    • Nursing turnover

• The role of outside consultants
  – You can’t be a prophet in your own village......
Leadership Initiatives

• Just Culture
  – Recognizes that human error is inevitable
  – Systems are developed to prevent human error from causing patient harm

• Root Cause Analysis
  – When incidents occur, is there a system for timely, robust analysis that involves all stakeholders?
  – Used to distinguish human error vs. at-risk behavior vs. reckless behavior
  – “Five whys” techniques to look for systemic shortcomings
Friend of Patient Safety

• **Standardization**
  – Leads to reduced errors in a complex environment
    • OR + ER + ICU = L&D
  – Establish through policies, procedures, standardized order sets
    • Especially important for high risk medications
      – Oxytocin
      – Magnesium Sulfate
  – Must be established by multidisciplinary teams
  – More important to do it the same than to do it right
Enemy of Patient Safety

• Disruptive behavior
  – Is there a code of conduct in place?
  – Is there zero tolerance for disruptive behavior?
  – Are subtle forms of disruptive behavior recognized?
    • Sarcastic tone of voice
    • Eye-rolling
    • Belittling
Promoting Teamwork

• Drills and simulations
  – In situ vs. simulation labs
  – Involve all stakeholders

• Joint fetal monitor training
  – Formal classes
    • NCC, AWHONN
  – Periodic fetal monitor review rounds

• Teamwork training
  – TeamSTEPPS
  – Others
Making It Stick

• **Executive walk-rounds**
  – By all leaders at the highest levels
  – All units and all shifts
  – Make safety the number one topic

• **Incident reporting mechanisms**
  – Multi-media, real time
  – Anonymous as an option
  – Feedback is critical
    • Even for anonymous reports
Implementation Science to Improve Quality Care and Patient Safety
• Methods to promote systematic uptake of clinical research findings into routine practice
• Evidence based improvement strategies
• Factors associated with successful translation of evidence into practice

8 Key Implementation Factors

• Preparing for change
  – Organization has planned for the change

• Capacity for Implementation: People
  – Enough with necessary skills to implement

• Capacity for Implementation: Setting
  – Capabilities and a receptiveness for change

• Type of Implementation
  – Chosen projects meets the needs for the org.
  – Is the best fit for the stakeholders and the org.

8 Key Implementation Factors

• Resources
  – Necessary human and financial resources available throughout the process

• Leverage
  – Support and momentum throughout the process

• Sustainability
  – Process to support mid-to-long term acceptance
8 Key Implementation Factors

• Desirable features
  – Champions
  – Effective planning, clear strategy
  – Project management
  – Teamwork & Communication
  – Evaluation and Feedback
  – Flexibility
  – Standardization
  – Autonomy
  – Tailoring implementations to the local context

Q&A Session
Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Empowering Patients, Improving Outcomes

Wednesday, May 20th | Noon ET

Ileana Balcu
Society for Participatory Medicine

Eleni Tsigas
The Preeclampsia Foundation

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