

# Participating in Safety at all Levels of the Organization

New York State Partnership  
for Patients  
Unit Based Safety Team  
Webinar  
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**Part I.**  
**Introduction and**  
**Quick Review**



# What Have We Learned About Engaging Staff During Times of Change?

Organizations that foster a culture of highly engaged caregivers are best positioned to prevent harm, improve quality, build resilience, and advance the overall patient care experience (Brooke Petrillo, MA)

Caven, S. (2017). Maintaining engagement during times of change. *Voice of Nursing Leadership*. 15(2), 18-19.

# What Have We Learned About Engaging Staff During Times of Change?

High levels of workplace engagement increase personal initiative and innovation which in turn translates into safer nursing practices, effective care, higher levels of effectiveness and reduces patient mortality rates

Scanlon, K.A. & Woolforde, L. (2106). Igniting change through an empowered front line: A unique approach centered on staff engagement, empowerment, and professional development. *Nurse Leader*, 14(1), 38-46.

# Gaining Staff Engagement in Times of Change

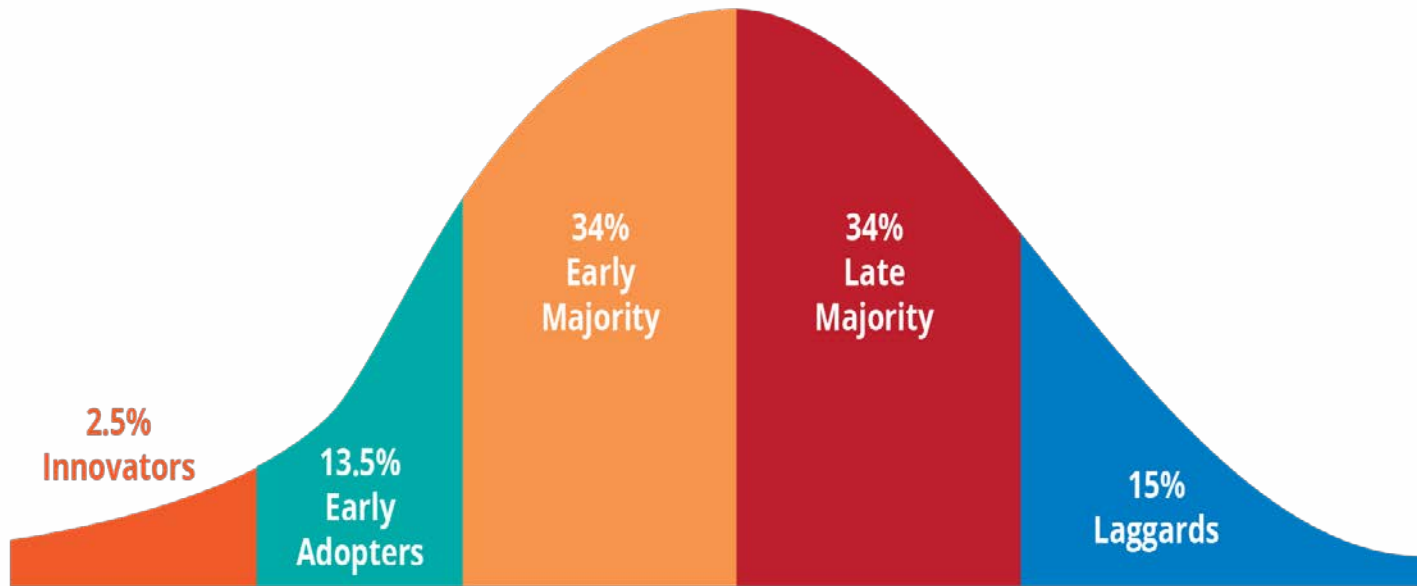
*“The new critical mass is only 20% of your intended audience so don’t wait for 100% buy-in before you make your move.”*

Tim Porter O’Grady  
AONE Transforming Care  
Conference  
11/2/2015



# Rogers Change Adopter Categories

Rogers, E. M. (2003). Diffusion of Innovations. 5th Edition. New York, N.Y: Free Press

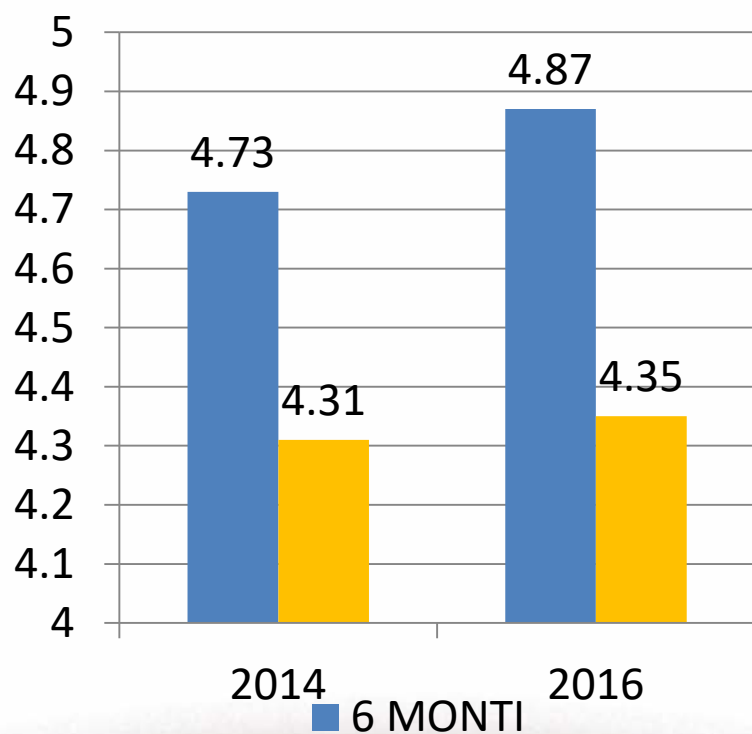


# Adopter (Staff) Response to Change

## Adopter Categories:

1. innovators (2.5% of the staff) – Gatekeepers
2. early adopters (13.5% of the staff) – Opinion Leaders
3. early majority (34% of the staff) – Deliberators
4. late majority (34% of the staff) – Skeptics
5. laggards (16% of the staff) – Traditionalists

# Findings From Engaged Staff Participating in Change Initiatives



## NDNQI Indicator: Nurse Autonomy

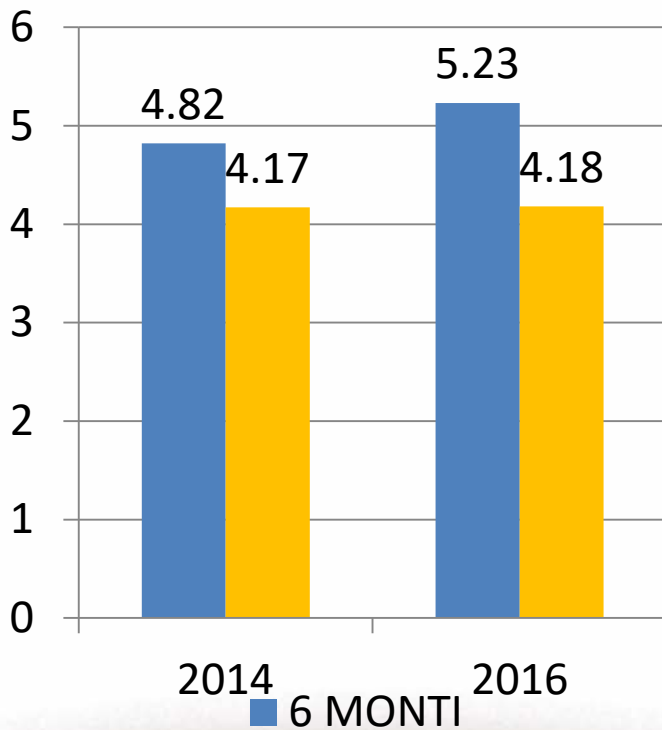
Response options & scoring:

*1=strongly disagree; 2=disagree; 3=tend to disagree; 4=tend to agree; 5=agree; 6=strongly*

1. As RNs we have sufficient input into the program of care for each of our patients
2. RNs on our unit have a good deal of control over our own work
3. As RNs, we are free to adjust our daily practice to fit patient needs



# Findings From Engaged Staff Participating in Change Initiatives



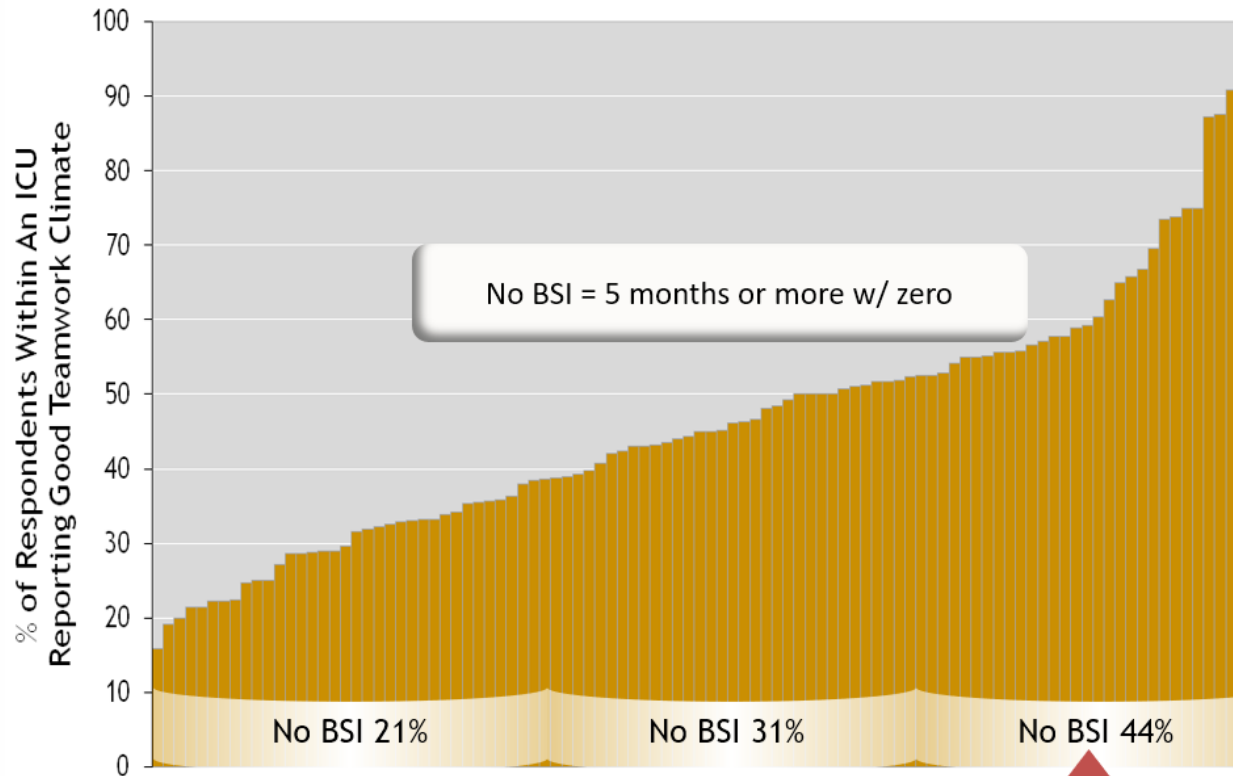
## NDNQI Indicator: Professional Status

Response options & scoring:

*1=strongly disagree; 2=disagree; 3=tend to disagree; 4=tend to agree; 5=agree; 6=strongly*

1. RNs are satisfied with the status of nursing on our unit
2. RNs recommend our unit as a good place to work
3. Work contributes to a sense of personal achievement for RNs on our unit

# A Third Finding from Engaged Teams: Teamwork Climate Across Michigan ICUs

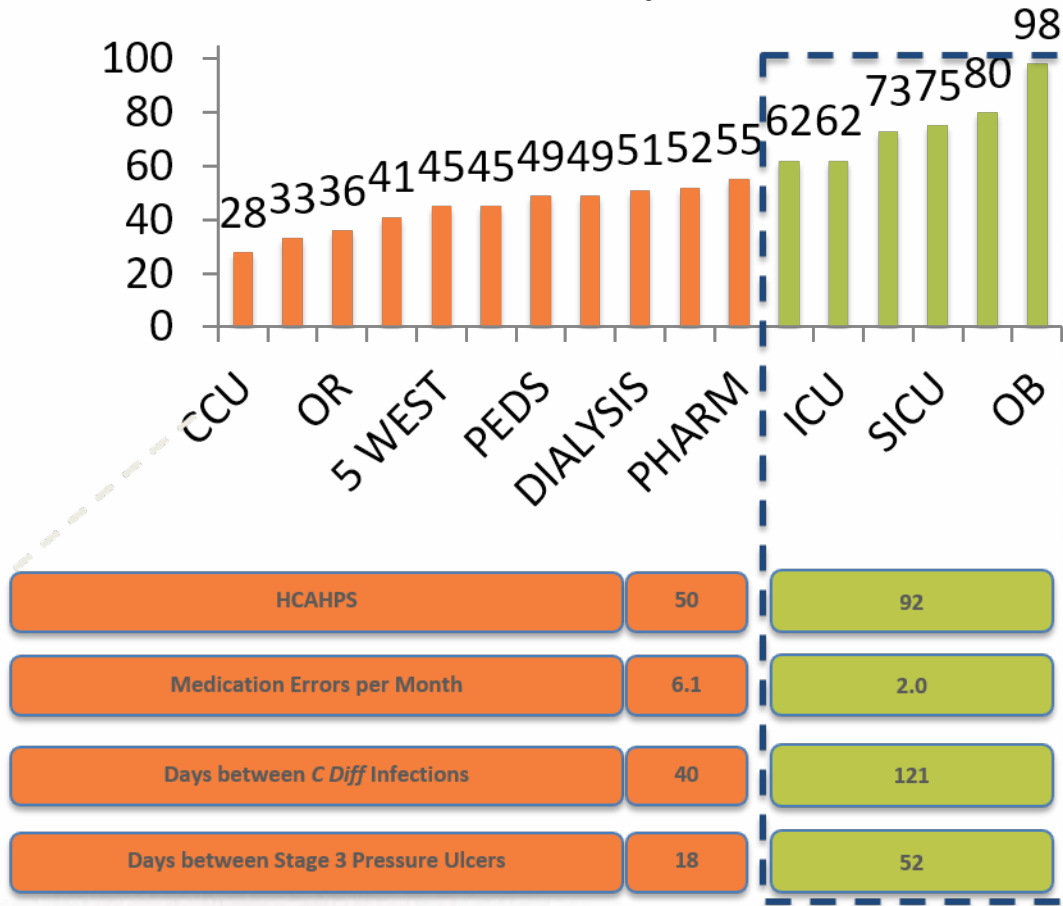


The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care

Attribution Bryan Sexton

# Engaged Teams and Safety Outcomes

Teamwork Climate Scores Across Facility



*Illustrative Data:  
Extracted from  
Blinded Client Data*

*Source: Dr. Michael  
Leonard*

**Part II.  
Leadership  
Practices to  
Impact Positive  
Outcomes**



# Leadership Practices

- Model the way
- Inspire a shared vision
- Challenge the process
- Enable others to act
- Encourage the heart

# Practice #1: Model the Way

Engaging staff on this journey is a top down initiative

Cannot get staff buy-in without leadership buy-in

Executive team must set the structure for engagement and hold others accountable for engagement

Leaders must model desired behaviors

Actions must align with mission, vision, and values

**Actions speak louder than words**

# Leader Rounding



# Case Example: Executive Rounding/Leader Walk-a-Rounds

- Provide Executive Leaders bulleted information about unit based projects in advance of the rounds
  - Results/outcomes but also actions
- Leaders round to unit based staff involved in the projects
- Ensure visibility of work on unit for rounding: Post results, create posters, team photos, results of brainstorming – evidence of staff involvement
- Nurse Managers should “manage up” unit based staff involved in this work



# Tips for Rounding

- Bring leaders to the unit – incorporate in existing processes like daily huddles or shared governance meetings
- Round to the staff not just the manager – manage up the “worker bees”
- Ensure that the staff are doing the talking and presenting
- Show them more than the data – **Remember data is not the goal!!!**
- Make the work visible



## Practice #2: Inspire a Shared Vision

Leaders must set the vision for quality, safety and performance improvement and influence others to share that vision

Leaders create a culture embedded throughout the organization and communicate a vision that others can believe in

## Case Example: Manager Huddles

- During huddles **every day** connect back to the bigger strategic vision – quality, safety and satisfaction for every patient and family
- 2 way communication is critical during huddles – need to listen and build trust so you can better understand why the unit/team is not performing
- **Participation is an expectation not an invitation**
- Help staff understand culture does not change if behavior doesn't change and that means everyone!

# Manager Huddles



## Case Example: Manager Huddles

- Need to call out publically those living the culture and work 1 on 1 with those who are not – convey “this is now the way to do business” and why you are important to me and this journey – what can you offer
- Review the stages of change adoption, implement strategies to engage each level of employee and recognize even laggards can change and become part of the vision

# Tips for Huddles

- Go to where the staff exist for huddles – nursing station, break room, by the KPI board (where the work is being made public)
- Keep them brief but make them meaningful – 1-2 key learning points per day (not meant to be a recap of everything happening in the hospital)
- Create a theme around the project
- Provide fun “rewards” and treats for all

## Practice #3: Challenge the Process

Challenge the status quo and lead the way as an innovator or early adopter

Demonstrate a willingness to listen to new ideas and take risks

Leaders ask *what should be* instead of what is

## Case Example: Staff Handoffs

Use the Staff Handoffs as a way to:

- Hold one another accountable for test of change initiatives – 1:1 way of validating competency
- Provide one another feedback – way to communicate and educate
- Manage one another up including non-RN staff members
- Be open and listen to what is not working
- Elicit new ways to adapt and retest



# Staff Handoffs



# Tips for Handoffs

- Help create the story and the meaning for each particular patient as part of the handoff
- Reinforce critical aspects of the change initiative using checklists or other visible reminders of the “to do’s”
- Listen and provide suggestions or resources for barriers to meeting bundle expectations

## Practice #4: Enable Others to Act

Share decision making and power to enable others to move in the direction of the vision

Allow structure and process to ensure resources to support your quality, safety and performance improvement initiatives

# Case Example: Developing Safety Champions

- Avoid recreating the wheel whenever you can
- Identify mechanisms already in place to support efforts on the unit based safety program
  - Quality departments, shared governance councils, CUSP projects, Lean Office, KPI Boards
- Just as some front line staff excel as the “diabetes resource person” or the “wound care guru” seek out staff who want to be the unit based safety program champion(s) for the unit

# Tips for Developing Safety Champions

- Recognition of champions for this initiative
  - Special name badge, lab coat/scrub jacket
- Set up work conditions to ensure that success will happen
  - Dedicated time to work on this project**
  - Monies in the budget to support the champions' work
  - Staff must sign a commitment statement
  - Unit Based Safety Program a performance expectation
  - Part of new hire orientation and expectations
  - Hardwire reporting into staff meetings and huddles

## Practice #5: Encourage the Heart

- Provide encouragement and feedback
- Recognize contributions employees make
- Celebrate victories and reward desired behaviors

# Case Example: Enhancing Staff Engagement

- Use stories to create the heart
- Behavior fueled by emotion lasts longer than that fueled just by analysis
- Address the emotions around change
- Be visible and focus on communication –  
Posters, Power Point presentations, bulletin boards, newsletters, Facebook page, group texts
- Support success along the way

# Case Example: Enhancing Staff Engagement

- Recognize – award effort not just outcomes
- Allow staff to think outside the box – no idea is a bad idea
- Meaningful recognition
- Educate about your initiative via branding, “naming” initiatives after staff, highlight or shout out boards
- **Checklist Note:** Are you sure every staff member on that unit has a voice and knows their commitment is expected? (nights, weekends, part-time, newly hired)



# Tips to Enhance Staff Engagement

- Educate, educate, educate!
- Communicate, communicate, communicate!
- Reward and recognize, reward and recognize, reward and recognize!

# Connecting to Purpose: My Story



# Why We Do What We Do



# Brand the Initiative

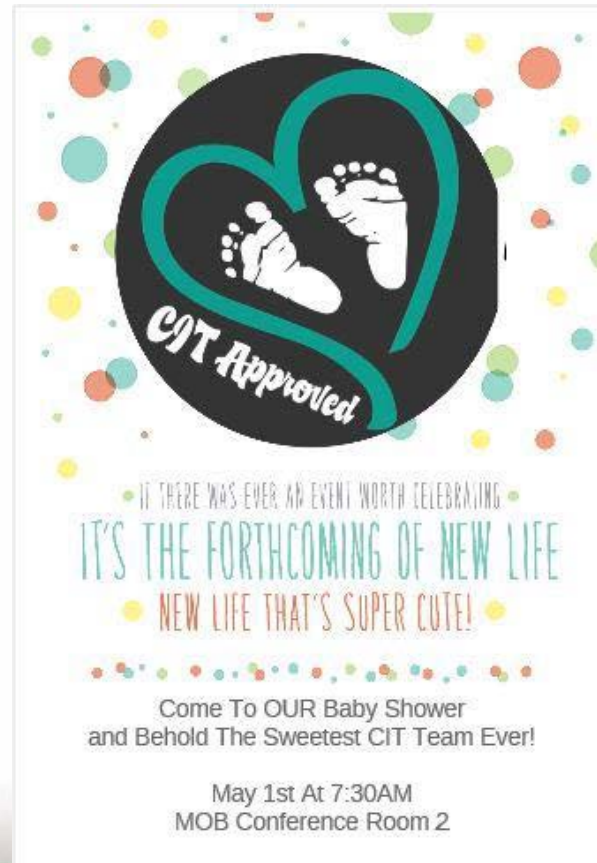
## “Going for the Gold”



Exciting! Challenging!  
Energizing! Motivating!  
Rewarding!



# Send Out Personalized Invitations to Join the Initiative



# Commitment to the Culture Change for Quality and Safety



# Highlight Your Unit Safety Champions



(From left to right)  
Danielle Somerville, BSN RN  
Hayley Cross, BSN RN  
Kirsten Puchovich, BSN RN  
Yarma Beyan, RN

& Our Newest Team  
members (Not Pictured): Lisa  
Lewis, RN  
Collette Gayton, BSN RN

# Reward and Recognition - Physician of the Month



Fifty-four nomination forms were turned in over a 5 month period, showing staff engagement.

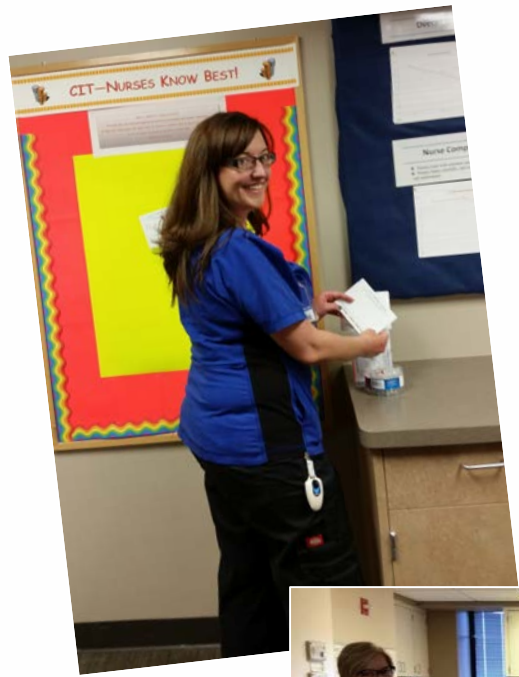


*"I think this recognition is meaningful in many ways, but especially so because it is a validation that the way I conduct myself is consistent with the way other health care professionals want to see their physicians behave. It is also a testament to my own mentors and colleagues who have shaped who I am as a physician."*

*- Dr. Kenji Muro, Neurosurgeon, Physician of the Month December 2011*



# Educate and Communicate About the Unit Safety Program



**CIT - Core Innovation and Transformation**

**TIMELINE**

**November 2014**  
**Congratulations!**  
 3rd Floor Staff was selected to participate in the national CIT program.

**March 2015**  
**Hot of the Starting Gate!**  
 Staff Action, Review, Share, Plan, Implement, and Evaluate. Share your ideas, thoughts, and suggestions for the program.

**April 2015**  
**Update!**  
 "Looking to Change" meeting with 3rd Floor Staff.

**May 2015**  
**In the Know!**  
 Bulletin board placed in break room to communicate program and projects.

**And We're Off & Running!**  
 Project implementation can't wait!

**Update — May 1, 2015**

Bulletin boards have been placed in the break room and bathroom to keep everyone up to date and give you an area to share your ideas and suggestions about projects.

**Important Dates!**

**Friday, May 1 - Tuesday, May 12**  
 Write your suggestions on idea cards and pin them on the main bulletin board for everyone to see.

**Thursday, May 15 - Monday, May 25**  
 Vote for your favorite(s) by placing vote cards in a ballot box.

**Wednesday, May 27**  
 The top suggestion will be announced—If this project sounds fun and interesting to you, think about signing up for the project team!

We will be continually working on projects so you can volunteer right away or for a later project.

**Coming Up**

Look for detailed information about how our improvement process will work, including starting points, end points, and sets of change using Plan, Do, Study, Act (PDSA) cycles.

**Change - Nurses Know Best!**

# The Beginning and the End of the Story About Change

Staff have to understand their value in the patient care experience – they are not just task performers but rather uniquely prepared professionals who can impact each safety, quality and satisfaction for every patient and family every day!

# Questions or Comments?

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