Leadership Influence on Professional Nursing Practice and Quality of Care

Jeanette Ives Erickson, RN, DNP, FAAN
Chief Nurse and Senior Vice President for Patient Care
Massachusetts General Hospital
<table>
<thead>
<tr>
<th>Agenda</th>
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<td>1. Articulate importance of a structure for clearly understanding fundamental standards and measures of compliance, accepted and embraced by the public and healthcare professionals with rigorous and clear means of enforcement.</td>
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<td>2. Identify strategies for creating a culture for openness, transparency and candor throughout the system.</td>
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<td>3. Describe mechanisms to improve support for compassionate, caring, and committed nursing.</td>
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<td>4. Affirm significance of developing a strong patient-centered healthcare leadership team.</td>
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<td>5. Illustrate methods to collect, implement and utilize accurate, useful, and relevant information.</td>
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"Houston, we have a problem." Jim Lovell
A Massachusetts General Hospital patient died last month after the alarm on a heart monitor was inadvertently left off, delaying the response of nurses and doctors to the patient’s medical crisis.

Hospital administrators said they immediately began an investigation, which led them to inspect and disable the off switch on alarms on all 1,100 of Mass. General’s heart monitors within a day of the death. The hospital also has temporarily assigned a nurse in each unit to specifically listen for alarms, out of concern that sometimes even functioning alarms can’t be heard over the din of a busy ward.

Patient safety officials said the tragedy at Mass. General shines a spotlight on a national problem with heart sensors and other ubiquitous patient monitoring devices. Numerous deaths have been reported because alarms malfunctioned or were turned off, ignored, or unheard.
# MGH Sentinel Event

## Event
- 90 year-old male surgical patient with complete heart block sent to CICU
- Plan for pacemaker in a few days
- Transferred back to surgical unit on a cardiac monitor
- Found in cardiac arrest
- Code Blue activated
- Patient expired

## Post-Event
- RNs discovered monitor alarms were off
  - Filed safety report
  - Alerted leadership
- Monitors, pumps, etc… investigated
- Root cause analysis initiated
- Reported to Department of Public Health
- MGH launches Interdisciplinary Physiologic Monitoring Tiger Team
  - Physiologic Monitoring Criteria
  - Physiologic Monitoring Assessment
  - Physiologic Monitoring Practice
  - Standards
Professional Practice Model

• Provides a comprehensive view of the components of professional practice and the contributions of all disciplines engaged in patient care. The model reflects an organizational commitment to teamwork in an effort to facilitate optimal patient care.

*MGH Patient Care Services*

• Creates a practice setting that best supports professional nursing practice and allows nurses to practice to their full potential.

*American Association of Colleges of Nursing, 2010*
Professional Practice Model

- Vision & Values
- Standards of Practice
- Narrative Culture
- Clinical Recognition & Advancement
- Patient-Centeredness
- Innovation & Entrepreneurial Teamwork
- Professional Development
- Collaborative Decision-Making
- Research & Evidence-Based Practice

© MGH Patient Care Services, 1996; 2007
Internal Evaluation: Staff Perceptions of the Professional Practice Environment Survey

• Provides a report card for reflection and future direction
• Evaluates the effectiveness of the Professional Practice Model based on eight professional practice environment (PPE) characteristics:
  - autonomy
  - control over practice
  - clinician-physician relationships
  - communication
  - teamwork
  - conflict management
  - internal work motivation
  - cultural sensitivity
• Identifies opportunities for improvement
• Trends data over time
Since we Developed our Survey

- **Publications:**
  

- Translated into five languages; used in 18 countries

- Tool requested by over 105 institutions for evaluation or research

- Five-hospital study conducted
Global Issues in Nursing & Health Care

External Evaluation: Magnet Recognition

- Structural Empowerment
- Transformational Leadership
- Exemplary Professional Practice
- New Knowledge Innovations & Improvement
- Empirical Outcomes

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MASSACHUSETTS GENERAL HOSPITAL

MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION
Just Culture

“The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.””

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement

“Did you commit this error on purpose? Then it’s my fault – errors stem from systems flaws…I am responsible for creating safe systems.”

Jeanette Ives Erickson, RN
Chief Nurse
Senior Vice President for Patient Care
Massachusetts General Hospital
Just Culture

“People make errors, which lead to accidents. Accidents lead to deaths. The problem is seldom the fault of the individual; it is the fault of the system. Change the people without changing the system and the problem will continue.”

Don Norman
Author, the Design of Everyday Things
Just Culture

1. Emphasizes quality and safety over blame and punishment.
2. Promotes a process where mistakes/errors do not result in automatic punishment but a process to uncover the root cause of the error.
3. Human errors that are not deliberate or malicious result in coaching, counseling, and education to decrease the likelihood of a repeated error.
4. Promotes increase error reporting that leads to system improvements to create safer environments for patients and staff.
# Accountability for Behavior

<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
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</table>
| Inadvertent action:  
- slip, lapse, mistake | A choice:  
- risk not recognized or believed justified | Conscious disregard of unreasonable risk |
| Manage through changes in:  
- Processes  
- Procedures  
- Training  
- Design  
- Environment  
- Choices | Manage through:  
- Removing incentives for at-risk behavior  
- Creating incentives for healthy behaviors  
- Increasing situational awareness | Manage through:  
- Punitive action |

## Console

## Coach

## Reckless Behavior
Proactive Learning Culture

- Not seeing events as things that are broken and need to be fixed.

- Seeing events as opportunities to improve our understanding of risk
  - System risk
  - Behavior risk
Weak
- Double checks
- Warnings
- Training
- New procedures

Intermediate
- Redundancy
- Increase staffing
- Checklists
- Standardize communication tools
- Education

Strong
- Simplify processes
- Standardize equipment and processes
- Force functions
- New devices with usability testing
- Physical plant changes
- Tangible involvement of leadership
Professional Accountability

• There is a social contract between society and a profession.
• Professions are the property of society and are responsible to society.
• Professions acquire recognition and relevance from society.
• It is society that determines what professional skills and knowledge are most needed and desired of a profession.
• Society grants professions authority over functions vital to itself and allows for autonomy in the conduct of their own affairs.
Nursing Accountability

• Nursing is responsible to society.
• Nursing must be perceived as serving the interests of society.
• Professions are therefore expected to act responsibly and mindful of the public’s trust.
• Self-regulation assures high quality performance and is the hallmark of a mature profession.
Nursing is:

The use of clinical judgment in the provision of care to enable people to improve, maintain, or recover health to cope with health problems, and to achieve the best possible quality of life, whatever their distress or disability until death.

Royal College of Nursing

The protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

American Nurses Association
MGH Culture of Safety

- Edward P. Lawrence Center for Quality and Safety
- Just Culture embraced
- Robust safety reporting – over 19,000 reports filed in 2012
- Root cause analysis
- Safety Culture Perception Survey
- Model to address professional conduct issues
Excellence Every Day

• Nursing Office of Quality and Safety

• Safety reporting structure, process, and outcomes for improvements and follow up

• Quality
  – Data driven
  – Nurse-sensitive indicators
  – Hospital-acquired conditions
  – Audits, surveillance, and prevalence
  – Quarterly Performance improvement plans

• Regulatory Compliance
• Magnet Recognition Program
• Service Excellence: Patient satisfaction
Guiding Principles

- Care delivery should always be: **patient and family-focused**, evidence-based, accountable and autonomous, coordinated and continuous.

- It’s important to **know the patient**.

- Inpatient and family care is provided by a **designated nurse and physician** who are accountable and responsible for continuity of care.

- **Continuity** of the team is a basic precept.

- Every novice team member deserves **mentoring** from an experienced clinician.

- Every **patient deserves** the opportunity to participate in the planning of his/her care.

- Advancements in technology create opportunity for **improved** provider communication and efficiency.
“Patient Journey” Framework

Before
- Preadmission Care
- Admission Process: ED, Direct Admits, Transfers

During
- Patient Stay; Direct Patient Care, Tests, Treatments, Procedures, Clinical Support, Operational Support

Post
- Discharge Process
- Post Discharge Care

Support Functions: Finance, Information Systems, HR

Goal: High-performing interdisciplinary teams that deliver safe, effective, timely, efficient and equitable care that is patient and family centered.

Where Are There Opportunities to Reduce Costs Across These Processes of Care?
Innovations in Care Delivery
Patient Journey Framework

Before
- Admission process: ED, direct admits, transfers
- Pre-admission care

During
- Patient stay; direct patient care; tests; treatments; procedures; clinical support; operational support
- Interventions:
  - Relationship-based care
    - Increased accountability through the attending nurse role
    - Utilization of Evidence Based staffing and care delivery;
    - Utilization of the Hand-Over Rounding Checklist

After
- Discharge process
- Post-discharge care

Goal: High-performing, inter-disciplinary teams that deliver safe, effective, timely, efficient, and equitable care that is patient- and family-centered

The Interventions
- Enhance clinical data-collection before admission
- Create Innovation Unit Welcome Packet
- Engage Patients and families in redesign
- Revise Domains of Practice
- Implement inter-disciplinary team rounds
- Install unit census and in room whiteboards
- Utilize communication devices
- Utilize wireless laptop computers
- Business cards
- Hourly rounding
- Quiet hours
- Implement Discharge Follow-up Call Program
Relationship Based Care

• A model for transforming practice
• Three crucial relationships
  – Care provider’s relationship with patients and families
  – Care provider’s relationship with self
  – Care provider’s relationship with colleagues
• Incorporates a formula for leading change with:
  – Inspiration
  – Infrastructure
  – Education
  – Evidence
  – Bolstered by 5 Cs – clarity, competence, confidence, collaboration, commitment

M. Koloroutis, 2004
Patient Safety is most effectively safeguarded when an advocate (most often the nurse) in the health care system knows the patient, family, and what matters most to them.
Attending Nurse Role

Responsible Nurse/Attending Nurse
Expand staff nurse role

- Accountable for patient/family **continuity** and **progression** along the developed overall plan of care from admission to discharge
- Ensures, along with the Attending MD, that patient care meets the unit’s clinical standards and vision of patient- and family-centered care
- Develops and revises the patient care goals with the clinical care team daily
- Coordinates meetings with clinicians for timely decision making and connects nurses to optimize handoffs across the continuum
- Is the primary bedside communicator with the patient and family, discussing plan of the day, care progress, potential discharge, and answers questions/teaches/coaches
# Innovation Unit Dashboard (Excerpts)

## Throughput and Efficiency
- LOS
- TSI bud/flex
- Wait time for bed to be ready
- Admits
- Medication turnaround time

## Patient & Staff Satisfaction
- MD & RN Communication
- Responsiveness
- Cleanliness
- Noise reduction
- Staff perception of support
- Equitable care

## Quality and Safety
- Unplanned Return to OR
- Readmission Rate
- Restraint Free Rate
- Falls/Pressure Ulcer Reduction
- Foley Catheter Days
- Hard-stop Time Out Performance

### Massachusetts General Hospital - PCS Innovation Units Dashboard

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### Note: metrics to be reported beginning FY 2012
- Catheter-associated Urinary Tract Infections per 1,000 Device Days
- Ventilator-associated Pneumonia per 1,000 Vent Days

**Color Shading relative to Benchmark:**
- Rate is better (lower) than benchmark.
- Rate is worse (higher) than benchmark.

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**Massachusetts General Hospital - Innovation Unit Dashboard**

**July – September 2011**
A Strong Safety Culture

1. Creates a learning culture
   • Foundation of patient safety
2. Creates an open, fair and just culture
   • Encourage reporting
   • Reinforce accountability for safety at all levels
3. Designs safe systems
   • Systems have the greatest influence on patient safety
4. Manages behavioral choices
   • Critical thinking and decision making emphasizes the continuous evaluation of risk
   • Choices lead to desired safety outcomes
KEEP CALM AND STAY BOSTON STRONG
References


