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Strategies to Engage Frontline Teams and Leaders in Sustainable Change

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ABSTRACT

A rapidly changing healthcare environment requires organizations to engage staff and physicians in new ways. External forces and internal priorities with decreasing resources create the need for innovative strategies to improve clinical outcomes, engage staff and physicians and meet the needs of patients and families. Barriers to safe reporting and participation in improvement work must be overcome before staff will feel secure enough to be involved in quality and patient safety initiatives. Safety forums, Robust Process Improvement®, microsystem assessment and Kaizen methodologies were utilized to assess current state, prioritize initiatives, implement changes and engage frontline staff and physicians. A variety of strategies were identified that engage frontline staff and align executive teams with frontline teams and microsystem level leaders.

Background

A rapidly changing healthcare environment requires organizations to engage staff and physicians in new ways to decrease harm and improve care. External forces and internal priorities with decreasing resources create the need for innovative strategies to improve clinical outcomes, engage staff and physicians and meet the needs of patients and families. Hospitals and health systems must learn to balance patient satisfaction, quality outcomes, value and cost in addition to executing on strategy through performance improvement activities.[1]

Early detection of potential harm and improved communication and teamwork at all levels is critical to providing safe care. Engaging frontline staff and physicians at the microsystem level is the logical starting point to understand current state and identify key opportunities for improvement. A high performing microsystem is the foundation for creating an environment where patients receive the best possible care. "The essential elements of the microsystem include the patients, clinicians and support staff, information and information technology, and the care processes."[2] Starting with the needs of patients and their families, frontline teams are in the best position to identify barriers to reliable processes and the ideal source for designing change.

Decreasing waste and inappropriate use of resources, eliminating delays in care, improving care coordination, improving flow and eliminating healthcare associated infections and complications have been demonstrated to result in decreased cost and patient harm. Many healthcare systems are looking to other industries who have demonstrated high levels of safety over time using high reliability science. Chassin and Loeb describe three requirements for achieving high reliability in healthcare: leadership, safety culture and robust process improvement®.[3] Leadership commitment through a guiding vision and measurable goals, a culture that encourages employees to recognize and report error and a systematic approach to improvement creates high reliability organizations.

Leadership strategies often include executive rounding processes to improve relationships between frontline staff and physicians and senior leaders to increase reporting or recognition of potential safety events.

A culture of safety begins with shared beliefs and values and requires all caregivers to be accountable for the prevention of harm in their organization.[4] Lean, Six Sigma, Robust Process Improvement® and other performance improvement approaches are widely used to identify, measure and improve [5](after improve). However, improvement and change initiatives fail to achieve sustained improvement for a number of reasons. A recent study to understand barriers to change from the perspective of frontline teams revealed ten primary barriers with the top two findings to be "(1) poor implementation, planning and overly aggressive timelines and (2) failing to create buy-in/ownership of the initiative."[6] Without buy-in and participation from frontline teams, it is difficult to understand the underlying issues and build a case for change.[7]

Transparency around safety issues requires a culture to feel safe speaking up about their concerns without fear of any punitive action. Yearly safety culture surveys revealed a safety climate score of less than 80%, difficulty speaking up to attending physicians less than 60% and difficulty discussing errors less than 70% (see Fig. 1).

This presents a problem for engaging staff in improvement efforts especially in bringing up new safety concerns if they are worried about reprisal. The National Association for Healthcare Quality (NAHQ) has raised the issue about the need for protection within healthcare organizations for those staff who report safety problems and even personnel hired to perform quality improvement work. Reports of intimidation, harassment, legal threats, and licensure pressures have been reported. The NAHQ published a "Call to Action" for healthcare leaders to put in place a protective infrastructure that

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Fig. 1. NAHQ Action Items for Integrity in Healthcare Quality and Safety.

supports a transparent, accountable, and meaningful quality and safety program with non-punitive reporting to oversight groups both internal and external for staff at all levels.[8] The NAHQ "call" identified four components needed to ensure the integrity of healthcare quality and safety (Fig. 1).

Although the executive team bears responsibility for ensuring a safe environment, in our organization, there was no forum for frontline physicians and staff to meet regularly with the executive team to discuss patient safety concerns and develop solutions. Exposure to front line teams enables leaders to demonstrate their commitment to building a culture of quality and safety and increase transparency. Robust Process Improvement® is our system wide performance improvement model and was used as a starting point for a structured approach. Unit safety councils (discussed in the previous chapter) became a safe place to discuss events, processes or conditions that could compromise quality and patient safety. The rule is that reporting in that forum was safe and transparency encouraged so meaningful change could be explored.

Strategies for Engaging Staff

Opportunities to participate must be created such as:

- Focus groups with frontline teams and leadership to understand existing opportunities for the executive teams to interact with staff other than general rounding.
- A driver diagram serves as a roadmap for potential ideas to test (Fig. 2).
- Fishbone diagrams (Fig. 3) identify barriers and can be created and completed during targeted rounding with staff in the units instead of scheduled meetings.
- Leadership safety rounding with the chief nursing officer, chief medical officer and unit leaders to discuss safety concerns.
- Safety forums:
- Attend regularly scheduled meetings or huddles where safety concerns are discussed
  - Nursing shift huddles
  - Pediatric safety huddles
  - Multidisciplinary team rounds
  - Random walk rounds
  - End of month wrap up meeting
- Document and categorize variance reports to identify trends
- Analyze safety events requiring escalation and follow-up (Fig. 4)
- Safety card process for staff to report concerns outside of formal processes and meetings (may be signed or anonymous)
- Utilize a process map to understand key processes
- "Gallery Walks"—sessions for frontline staff and physicians to visualize completed process maps filled with post-it suggestions from staff/physicians, which identified opportunities for improvement and waste in key processes (Fig. 5).

Microsystem assessment[9,10] and Kaizen methodologies are effective strategies to assess current state, prioritize initiatives, and implement changes based on information learned.

Quick Wins Gains Momentum

Applying a systematic approach to improving key processes is the most effective strategy for reliably identifying the source of problems

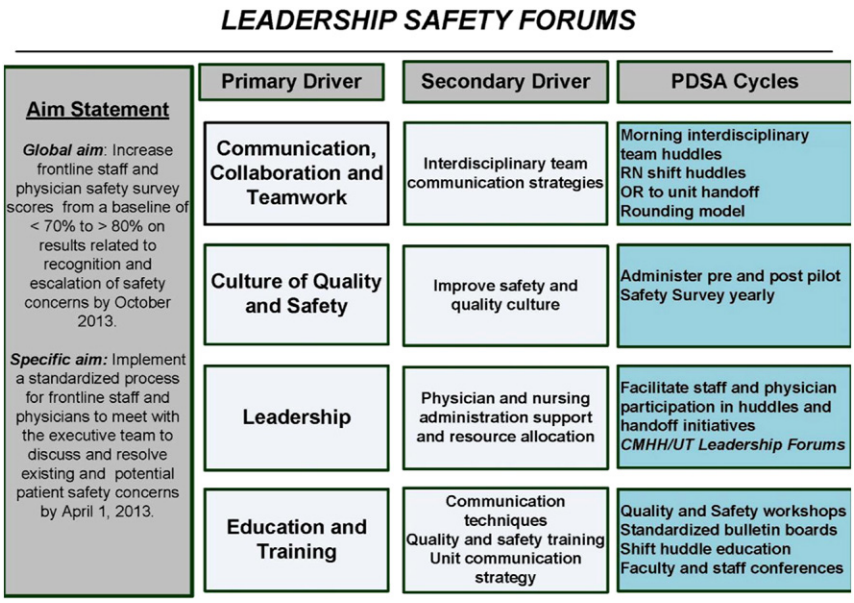

Fig. 2. Driver Diagram.