

Culture Change Toolbox



What's inside?

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BC PATIENT SAFETY
& QUALITY COUNCIL





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Most of all, thank you to everyone changing culture in surgical departments across BC. Your ground-breaking work is the inspiration for this collection of change ideas.

What is culture?

Culture is the way we think, our values, our attitudes, our perceptions, and our beliefs. It's also about how we act, our habits and our typical behaviours. It's not about one person. **Culture is about our shared beliefs, what we expect of each other, what's considered normal, and our shared patterns of behaviour** that determine how our organization functions. It's "the way we do things around here."

Culture is an umbrella term with many components, and in health care these may include: teamwork; communication; psychological safety to share ideas or input; ability to speak up about safety and discuss errors; respect and fair treatment of everyone; workload management; appropriate training of new and current personnel; and leadership approach.

Here are some concrete examples:

- Have you ever spoken up and felt like your input wasn't heard?
- Is it easy to ask questions if there is something that you don't understand?
- "We almost administered the wrong dose of a drug, but we caught it just in time. Do we talk about it or pretend it didn't happen?"
- "We are trying to figure out how best to position the patient for surgery. Do we solve this problem as a team, or do we argue about who is right?"
- Does your workload prevent you from doing your best work? For example, are you too busy to properly document or fill out paperwork?

Culture matters. Better culture means better outcomes for our patients and fewer adverse events. In root-cause analysis of more than 4,000 adverse events, the Joint Commission identified communication breakdown as the most common factor implicated in adverse events.¹ Academic evidence is growing that shows a concrete link between strong teamwork and increased safety and quality of care.² We are beginning to see how interventions that improve culture can change clinical outcomes for the better and reduce adverse events,³ although culture interventions are both a science and an art at this early stage in health care's movement toward a focus on safety culture. **Overall we improve our culture to help patients.**

How do we improve culture?

Culture has many components. In order to improve, we have to know where we are doing well and where we have opportunities. Maybe our teamwork is great, but we all have a high workload and experience stress. We can't know our strengths and opportunities unless we assess our culture.

We can assess culture through surveys, interviews, or direct observation. Many BC hospitals have used a survey that measures culture called the Safety Attitudes Questionnaire (SAQ). Below is a description of each component of culture measured by the SAQ and approaches to improvement in that area.

The SAQ components of culture are not air-tight compartments. They are heavily interconnected. We may focus on one part of culture in particular, but **the interventions and tools available often target multiple components of culture simultaneously or have a ripple effect.**

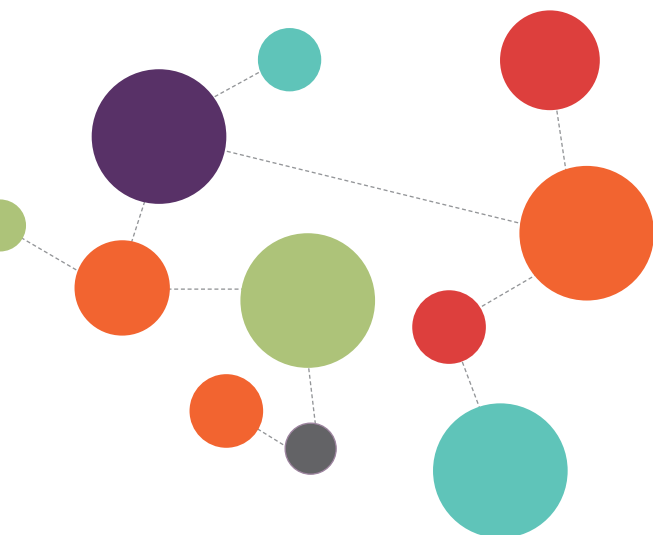


Component #1

Teamwork Climate

Teamwork Climate is the perceived quality of teamwork and collaboration within a given unit. A low teamwork climate stems from persistent interpersonal problems among the members of a given unit. When teamwork climate is low, employees feel that their coworkers are not cooperative, that their voices are not heard by management, and that their efforts are not supported. These feelings can deeply affect employee performance and patient outcomes.

Patterns of teamwork build up over time, so to change teamwork we make small changes over time that gradually bring about a shift in teamwork. To begin, identify a specific element of teamwork that is visible or offers an easy place to start. During interventions, encourage employees to support each other's work and help their fellow coworkers when problems – such as work overload or a problematic patient – arise. Through conversation and curiosity, try to understand why they might feel that they can't speak up or aren't being listened to when they do, and seek to address their concerns directly.





Component #2

Safety Climate

Safety Climate is the perceived level of commitment to and focus on patient safety within a given unit. **When employees indicate that they don't perceive a good safety climate, they are messaging that they don't see a real dedication to safety in their unit.** A low level of safety climate is significantly related to both caregiver safety (e.g. causing needlesticks, back injuries) and patient safety (e.g. causing bloodstream infections, decubitus ulcers) and so low safety climate is critical to address. Safety climate involves the ability to report safety concerns, discuss adverse events, and learn from past errors.

During interventions, emphasize the importance of keeping lines of feedback and communication open. Let employees know that it is okay to bring errors to the attention of managers and clinical leaders. Let managers and clinical leaders know that they need to be responsive to error reports and show appreciation for having errors brought to their attention. Look to tools that support communication, the psychological safety to provide input, and learning from past errors. Whatever intervention is selected to improve the ability of staff to provide input, being accountable to following up or taking action on that input is just as important.



Component #3

Job Satisfaction

Job Satisfaction measures employees' general feelings of positivity regarding their work experiences. Low job satisfaction scores indicate low employee morale and, generally, negative emotional reactions to employee work experiences. When job satisfaction is low, employees' performance is reduced and turnover is likely to be high.

To intervene, it is important to locate the source of low morale, which could be due to a range of factors such as:

- 1) The degree to which people feel their comments and contributions are met with respect by others throughout the organization.
- 2) Receiving reasonable pay or compensation for work.
- 3) The ability to be supported in advancing oneself in the organization.
- 4) People who advance are advanced fairly.

Use interviews or discussions to identify the source of low morale and design interventions accordingly. Look to tools in this guide that help people feel that their input is heard, or tools that promote teamwork and a sense of "us." Whatever intervention is selected to improve the ability of staff to give input, being accountable to following up or taking action on that input is just as important.

Component #4



Perceptions of Management (Senior and Local Management)

Survey questions here measure employees' beliefs about management's dedication to patient safety; support of frontline staff; and deliverance of timely information that affects their work. Overall low scores on this scale suggest that employees don't think management is particularly concerned about their well-being or patients' well-being. These perceptions can deeply affect employee morale and may be indicative of actual managerial problems.

The number one intervention to improve perceptions of management is to increase the visibility of leaders.

Another common intervention is to address problem personnel. Finally, providing adequate information and increasing transparency will also have a positive effect on perceptions of management. Before intervening, it is important to talk to employees and understand if any particular managerial behaviours led to these perceptions.

How do we define "problem personnel"? Problem personnel are generally of one of three types:

- 1) Those who exhibit abusive behaviour.
- 2) Those who avoid work.
- 3) Those who don't volunteer for "extras" or who take on less than others.

Find out which type of problem personnel are of greatest concern in your unit. The ability to address problem personnel falls mostly to management. Interventions can also focus on having all staff model a desired behaviour that is visibly supported by leadership.

Component #5



Working Conditions

This domain measures employees' perceptions of the quality of their work environment. The working conditions scale assesses employees' perceptions that new employees are adequately trained, problem personnel are adequately dealt with, and information vital to patient care is disseminated properly.

Two initial ways to improve working conditions are to increase the availability of information and address the training and supervision of new personnel. Training of existing personnel may be the major factor in some cases. Low scores may also suggest a gap between managers and employees, so include both groups when discussing improvements.

Component #6



Stress Recognition

Questions in the Stress Recognition domain measure employees' recognition of how stressors such as fatigue and hostility impact their performance. **When stress recognition is low, employees fail to recognize the link between their stress levels and their on-the-job performance.** Significant research has attested to the detrimental effects of stress on performance. Recognition of this relationship is integral to employees' utilisation of practices and policies that reduce employee stress and work overload.

The issues in this component may be addressed through education about human reactions under conditions of stress and by emphasizing the many ways in which stress can be problematic. For instance, it would be beneficial to highlight the fact that stressed and fatigued workers often make basic procedural errors that can compromise the safety of even routine procedures. Other interventions might remove interruptions, sources of fatigue, and other causes of stress from the work environment.







Tools to improve culture

An icon indicates that the tool has a positive effect on that component of safety culture.

	Teamwork Climate	Safety Climate	Job Satisfaction	Perceptions of Management	Working Conditions	Stress Recognition
Adverse Event Drills/Simulate Adverse Events		+				
Adverse Event Response Team		+				
Briefs and Debriefs	👥	+	👍			
Call-outs	👥	+				
Closed-loop Communication	👥	+				
Critical Language	👥	+				
“CUS” Words	👥	+				
Explicit Ask for Feedback	👥					
Feedback at the Front Line			👍	👜		
Huddles	👥	+	👍			
Leadership Visibility, Leadership Walk Rounds		+		👜		
Learning Board		+	👍	👜	★	
Learning from Defects		+				
Multidisciplinary Team Meetings	👥		👍			
Process Map	👥					
Roles and Expectations	👥					
Safety Briefings		+				
Safety Champion		+				
Safety Reports at Shift Changes		+				
SBAR: Situation Background Assessment Recommendation	👥	+				
Team Vision Statement	👥		👍			
Two Challenge Rule	👥	+				
Use First Names	👥					

Process changes to improve culture

An icon indicates that improving this process or procedure has a positive effect on that component of safety culture.

	Teamwork Climate	Safety Climate	Job Satisfaction	Perceptions of Management	Working Conditions	Stress Recognition
Documentation						
Handoffs						
Limit Interruptions						
Supervision and Training of New Personnel						
Training of Current Personnel						

Ideas for changing culture

This section describes tools that can be used to improve culture, processes that can be adjusted, and some techniques for generating your own ideas for change. These are just suggestions, so if you have other ideas, give them a try. Interventions are listed alphabetically.

Next to each tool or process change is a list of the component(s) of culture that it affects most. However, the components of culture are interconnected, so any intervention will have ripple effects and possibly improve other components of culture - sometimes in unexpected ways. Choose an approach that feels like a good fit for your work area and has support from your colleagues.

Once you have chosen some tools to try, go on to the next section for some tips on testing and applying them.

Tools

Adverse Event Drills/Simulate Adverse Events

IMPROVES:  SAFETY CLIMATE

Adverse event drills⁴ are a type of simulation and they can be used to practice responding to adverse events. Use these drills to practice communication techniques, practice speaking up about safety concerns, or train an adverse event response team.

Simulation is like role-playing or pretending. You can do simulation without any fancy equipment; it can be as simple as acting out a scenario. When we act out a scenario, we learn and practice the behaviours we want to

use if and when the situation actually occurs. Simulation can be used to practice the use of any behaviour, such as using a communication technique or responding to an adverse event. You can use examples that have occurred in your organization in the past to add an additional element of learning from past events.

1. Develop a script to act out. It is more powerful if it contains an example that is a frequent occurrence in your work area.
2. What do you want to achieve by going through this simulation? Embed a communication technique or other tool into the script. For example, practice using CUS words when responding to adverse events.
3. Identify the people that you hope will take part.
4. Fine tune the script by trying it first with a group of people who are already interested in changing your work area's culture.
5. Use the script to train other team members. An intermediate step might be to have others watch the first group perform the simulation before practicing it themselves.

Adverse Event Response Team

IMPROVES:  SAFETY CLIMATE

It is often challenging to address an adverse event as it happens or immediately after. Sometimes the atmosphere is tense, or there is uncertainty about what to do. An adverse event response team is a group of staff with training to address adverse events. In addition to improving the response to individual events, the team members act as stewards of a positive safety culture in the moments when it is needed most. Members of the team may also be Safety Champions (another tool described here). According to the Institute for Healthcare Improvement⁵, the team can do the following:

1. Keep the atmosphere in the unit calm.
2. Do whatever is possible to mitigate harm to the patient and prevent further harm.
3. Prevent or reverse any undue punitive action. We don't want a culture of shame and blame.
4. Document the event or enter it into the Patient Safety & Learning System.
5. Review what happened or learn how to prevent future events.
6. Support the family, staff, and physicians.

To create an adverse event response team, ask for volunteers from all disciplines. Ensure the team covers all days of the week and all shifts, and maintain membership when there is staff turnover. Depending on the purpose chosen for your adverse event response team, training may be required in conflict resolution, communication techniques, emotional support, and the procedures for incident review. Look for internal resources in your organization for this training. Have the team practice by doing simulations or adverse event drills. Finally, promote the team in its work area so everyone knows what it's about, and clearly describe the process for calling the team members together when they are needed.

Briefs and Debriefs

IMPROVES:  SAFETY CLIMATE,  TEAMWORK,  JOB SATISFACTION

Briefs and debriefs are short, scheduled meetings that are typically effective when a large number of people are working together. They come as a pair and occur before and after a given procedure or shift. During the **briefing**, share the plan for the procedure and review the major pieces of information. During the **debriefing**, ask three questions: 1) What did we do well? 2) What could we do better? 3) What do we want to do differently tomorrow or next time?

1. Think about which procedure or care team would benefit from a brief/debrief. Identify which people need to be present.
2. Develop a structure for the conversation. Will you use a checklist or a set of key questions? Will you use SBAR: Situation Background Assessment Recommendation, another tool described here?
3. Think about practicalities. Who will host the conversation? How long will it be? Are all staff able to speak up during the briefing?
4. Try it first with one procedure, one time and with a group willing to try something new. Continuous changes to the structure of the brief/debrief may be necessary. Once the structure is working well, expand the use to more people in the work area, but continue to make small changes as needed.

Note: The same logic is behind the Surgical Safety Checklist; briefing and debriefing are the first and third phases of the Checklist.

Call-outs

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

A call-out is when someone vocalizes or shouts out an important piece of information. These are often used during emergency situations but can be useful at other times too. For example, a nurse might call out what dose of medication she is giving to a patient. Pieces of information that all team members need to know are good topics for call-outs.

1. Define particular circumstances under which call-outs are expected to be used. Start small, for example by using call-outs for a specific type of medication during a particular procedure. Fine tune the technique by testing it with a small group willing to help you. Practice by doing role plays or simulations.
2. Spread the technique to other staff, ensuring that it covers people working during all shifts and part-time staff. Practice by doing role plays or simulations.
3. Spread the use of the technique to other procedures, patient populations, etc.
4. Maintain its use by having respected and influential team members lead by example.

Closed-loop Communication

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

When we communicate with others, we cannot know that they heard us as intended unless they tell us what they heard. This is the idea behind closed-loop communication; we always want to ensure the message was transferred as intended. Below are some examples of closed-loop communication. In these examples, the details are repeated in the response.

“Dr Smith, I’m calling about a Critical Action Value for Patient Jones, MRN12345. Her glucose is 48.”

“Ok - Mrs. Jones, MRN12345, has a glucose of 48. I will call the floor immediately and ask them to bolus D50 stat”.

Doctor: “Please give 0.5 ccs of epinephrine!”

Nurse: “0.5 ccs of epinephrine given.”

1. Define particular circumstances under which closed-loop communication is expected to be used. Start small, for example you might start closed-loop communication when administering a particular medication during a particular procedure, and then expand the practice to other medications or other procedures.
2. Fine tune the technique by testing it with a small group willing to help you. Practice by doing role plays or simulations.
3. Spread the technique to other staff, ensuring that it covers people working during all shifts and part-time staff. Practice by doing role plays or simulations.
4. Spread the use of the technique to other procedures, patient populations, etc.
5. Maintain its use by having respected and influential team members lead by example.

Try this “O.R. Telephone” exercise from Safe Surgery 2015: South Carolina⁶ to practice closed-loop communication.

The goal of this exercise is for participants to understand closed-loop communication and the potential benefits that it can have when communicating in the operating room. We have outlined the materials needed and instructions on how to perform this exercise below. We recommend performing at least two rounds of this exercise, first using memory only and then using memory aids.

SIZE OF BREAKOUT GROUPS: 6-10 people

MATERIALS: One copy of messages for each breakout group (see below), one piece of paper per person, one pen or pencil per person, and clipboards or something to write on.

INSTRUCTIONS:

Round 1 – Memory Only

1. Have each group form a line.
2. The facilitator for each breakout group will whisper or quietly tell the first person in line the message. Once the individual receives this information, he/she is not allowed to ask questions, clarify, or write it down.
3. That person then whispers what he/she remembered/heard to the next person in line.
4. This should be repeated until every person in the line has heard the message.
5. Once the last person in line hears the message, he/she should tell the group what he/she heard.
6. The facilitator should then tell the group the original message.
7. The group should then talk about what happened to the communication in the exercise.

Round 2 – Closed Loop Communication and Memory Aids

1. Have the group form a line again.
2. Tell the group that the rules are different for this round of the exercise. This time when people receive the message they should write it down and read the message back to the person that gave it to them. The person that gave the information can clarify or repeat the message.
3. The facilitator will whisper or quietly tell the first person in line the message.
4. The person that receives the message should write it down and read it back to the person that gave him/her the message. If anything needs to be clarified, it can happen at this time.
5. That person then whispers the message to the next person in line. The person that receives the message can write it down and will read back the information to the person that gave it to him/her.

6. This should be repeated until everybody in line has received the message.
7. Once everybody has heard the message, the last person in the line will share the message that he/she received with the group.
8. The group should then talk about what happened to the communication in the exercise and if using closed loop communication and writing the message down helped the message remain intact.

EXAMPLE EXERCISES

1. Please order Gentamicin 80 mg, metronidazole 750 mg, and 600 mg of clindamycin all mixed in a 50 cc bag of D5 1/2 NS. I need it in 25 minutes.
2. Please order 3 units of packed red blood cells, 4 units for fresh frozen plasma, 10 units of cryoprecipitate and obtain a PT, PTT and fibrinogen level. The patient has an anti-Kell antibody.
3. Please go on bypass. Cool to 28 degrees centigrade and drift. I will be using blood cardioplegia and after the first dose I will want repeated doses to keep the myocardial temp less than 15 degrees at least every 25 minutes until we rewarm.
4. Could you please get a 25 mm EEA stapler with 4.8 mm staples and also an endo GIA Duet TRS 45-3.5MM Articulating stapler?
5. Mix 100 units of insulin in 250 mls of D20 with 30 milli equivalents of Potassium Chloride and 1 gram of Calcium Chloride.
6. Mrs. Jones just got back to the nursing floor from X-ray. She needs to have her IV restarted and get a dose of pain medication. The radiologist said she should have nothing by mouth for at least six hours and she needs to be kept in bed until midnight.

Critical Language

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

Critical language refers to an agreed upon phrase that can be used to “stop the line” or halt activity if someone feels safety is a concern. For example, the phrase “I need clarity” can be used as critical language in a scenario such as this one:

“Dr. Smith – I need clarity here. You ordered Zosyn for Ms. Jones, but her chart shows she has a penicillin allergy.”

1. Work with everyone in your work area to define terms that work for you. What will your critical language phrase be?
2. Fine tune the technique by testing it with a small group willing to help you. Practice by doing role plays or simulations. Ensure the simulation includes both the use of the critical language and the appropriate reaction (thereby stopping the current activity).
3. Spread the technique to other staff, ensuring that it covers people working during all shifts and part-time staff. Practice by doing role plays or simulations.
4. Maintain its use by having respected and influential team members lead by example.

“CUS” Words

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

“CUS” is an acronym that stands for the following:

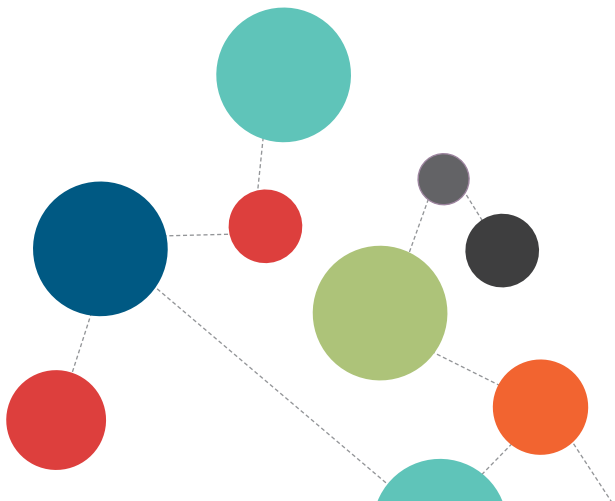
I’m concerned...

I’m uncomfortable... This is unsafe...

I’m scared... This is a safety issue... STOP.

This set of words is effective at increasing the level of concern about a safety issue without generating too much confrontation. Using CUS words can make it easier to speak up about a safety concern because it gives us something easy and automatic to say. All members of a team need to know that these words are meant to imply a safety concern.

1. Choose which words will be your CUS words. Will you use “uncomfortable,” “unsafe,” or both?
2. Make it common knowledge that these words are used to bring up safety concerns.
3. Practice! Try simulating conversations using CUS words. When faced with a tough situation, we are more likely to display desired behaviour if it has been practiced beforehand. Try having a third team member observe and coach as others practice using CUS. Alternate roles in the script to practice saying CUS words, and to practice hearing them.
4. Find key team members to lead by example.



Here are some scripts from Safe Surgery 2015: South Carolina⁷ to help with practicing CUS Words.

SCRIPT 1

Scenario: The patient is undergoing a laparoscopic cholecystectomy. The surgeon notices that the patient's blood pressure is falling.

Dr. Jones, surgeon: Anesthesia. I am concerned about the blood pressure. Is something going on?

Dr. Smith, anesthesiologist: It's fine. I know my job and it's fine.

Scenario: The blood pressure continues to fall.

Dr. Jones, surgeon: I'm really uncomfortable with the blood pressure where it is. I am going to stop. We need to do something. Can I call for another pair of hands?

Dr. Smith, anesthesiologist: I have everything under control here. The blood pressure is fine...

Dr. Jones, surgeon: This is a safety issue. Could you call for anesthesia back-up to come in now.

SCRIPT 2

Scenario: The patient is undergoing a total hip replacement. The nurse notices that the surgeon has contaminated the sleeve of his/her gown.

Betty, nurse: Dr. Jones. I think that you just brushed your arm against the electrocautery machine. I am concerned that you contaminated yourself.

Dr. Jones, surgeon: I don't think that I touched anything.

Betty, nurse: No, really Dr. Jones, I am uncomfortable with you proceeding without putting a new sleeve on or changing your gown. I am certain that you contaminated yourself.

Dr. Jones, surgeon: And I am certain that I didn't.

Betty, nurse: Dr. Jones, this is a safety issue. You really need to change and we need to stop now.

SCRIPT 3

Scenario: The patient is being intubated and the anesthesiologist is visibly struggling.

Betty, nurse: Dr. Smith? I am concerned that things aren't going well with the intubation. Can I assist you with anything?

Dr. Smith, anesthesiologist: Things are going just fine, it's just a little hard to see in here.

Scenario: The struggle continues and the patient's heart rate is increasing.

Betty, nurse: Dr. Smith? I am really uncomfortable with how this is going, I think we might need an extra set of hands. Should I call someone in?

Dr. Smith, anesthesiologist: I am certain that I can handle this. Just be quiet and leave me alone.

Scenario: The patient's oxygen saturation begins to fall.

Betty, nurse: This is a safety issue - I am calling for back-up. [the nurse walks to the intercom] Can we get some anesthesia help in the room please?

SCRIPT 4

Scenario: The patient is undergoing a laparoscopic adrenalectomy. The vital signs begin to change.

Dr. Williams, anesthesiologist: Dr. Smith? I am concerned, the blood pressure is dropping and the heart rate is going up, is everything ok down there?

Dr. Smith, surgeon: Everything is just fine... it's just a little difficult.

Scenario: The blood pressure continues to fall

Dr. Williams, anesthesiologist: Dr. Smith, this is really making me uncomfortable, the blood pressure is dropping, I gave some neo and fluids and things still aren't stabilizing. What's going on? Do you think we should call one of your partners?

Dr. Smith, surgeon: I think I might have to open but I can take care of it.

Dr. Williams, anesthesiologist: I think this is a safety issue. We need to get another pair of hands in here. Can you get me another anesthesiologist, some blood, and stat page one of Dr. Smith's partners?

After using these scripts, it might be helpful to discuss these questions:⁸

1. How does it feel to practice using CUS?
2. Could this be helpful in the ORs at your hospital?
3. How would you have handled this situation without CUS?
4. If you saw this happen in the OR while you were observing how would you have coached those involved after the case [later, outside of the OR]?

Explicit Ask for Feedback

IMPROVES:  TEAMWORK CLIMATE

Our ability to speak up depends on the situation, but also on our personalities. A great technique to increase input from all team members is to explicitly ask for feedback from them using their names. Ask, “**What do you think, Barbara?**” **Then say thank you!** Respecting and acting on the feedback is just as important as asking for it. This tool can improve the sense that input is valued and promote coordination between team members. It is particularly helpful when you want to break out of a pattern of silence, or when some members of your team are naturally shy. To implement this tool, think about the appropriate person to be asking for feedback. Is it a manager, a physician, or everyone on the team?

Feedback at the Front Line

IMPROVES:  JOB SATISFACTION,  PERCEPTIONS OF MANAGEMENT

The goal here is to increase communication at the front line and take appropriate actions to show input was received. There are a number of ways to give feedback at the front line such as regular safety meetings, Leadership Walk Rounds, poster boards, and personal follow-up on particular adverse events. Here are some tips from the Institute for Healthcare Improvement:⁹

1. Ensure that the feedback system reaches all staff members, including those who work on alternate shifts, on weekends, or intermittently.
2. Develop a newsletter for communicating safety information, or add a page or column to an existing newsletter. Make sure some messages come directly from senior leaders.
3. Recognize and thank staff members in front of their peers for their suggestions.
4. Give feedback about each suggestion even if you can't act on it: make sure the staff member who made the suggestion knows it was investigated and explain why you could not take action.
5. Make responses timely — failure to provide prompt feedback will make staff members think you don't listen or take action.

Huddles

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE,  JOB SATISFACTION

A “huddle” is when a team meets at a pre-determined time to review its recent work and/or plan ahead for future work.¹⁰ Huddles facilitate communication because they provide a forum in which regular communication is expected. They often apply when a large number of people are working together.

1. Think about which care team would benefit from a huddle. Start by asking team members what information they would like to discuss.
2. Identify which people need to be present.
3. Develop a structure for the conversation. Will you use a checklist or a set of key questions? Will you use SBAR (Situation Background Assessment Recommendation)? Focus on information that is immediately required to do one's work. Keep the huddle short. The exact structure of huddles can be adjusted through small changes every time and should meet each work area's unique needs.
4. Think about practicalities. Who will host the conversation? How long will it be? Are all staff able to speak up? Huddles are a great time to ask for feedback from each team member and demonstrate that input is heard by sharing updates and actions taken.
5. Try it once with a group willing to try something new and then expand, for example, to two days a week instead of one day a week. Continuous changes to the structure or agenda are important.

Leadership Visibility, Leadership Walk Rounds

IMPROVES:  SAFETY CLIMATE,  PERCEPTIONS OF MANAGEMENT

One of the most powerful ways to improve perceptions of management is simply to improve visibility of managers. This can mean sitting in the same cafeteria as everyone else to attending meetings. Some leaders use newsletters or blogs to increase visibility. Think about where leadership attendance is least expected - and go there! It will be uncomfortable at first as scepticism will probably be high, but, with persistence, this will change sooner than one might think. Any form of visibility will work, as long as it is regular and long-term.

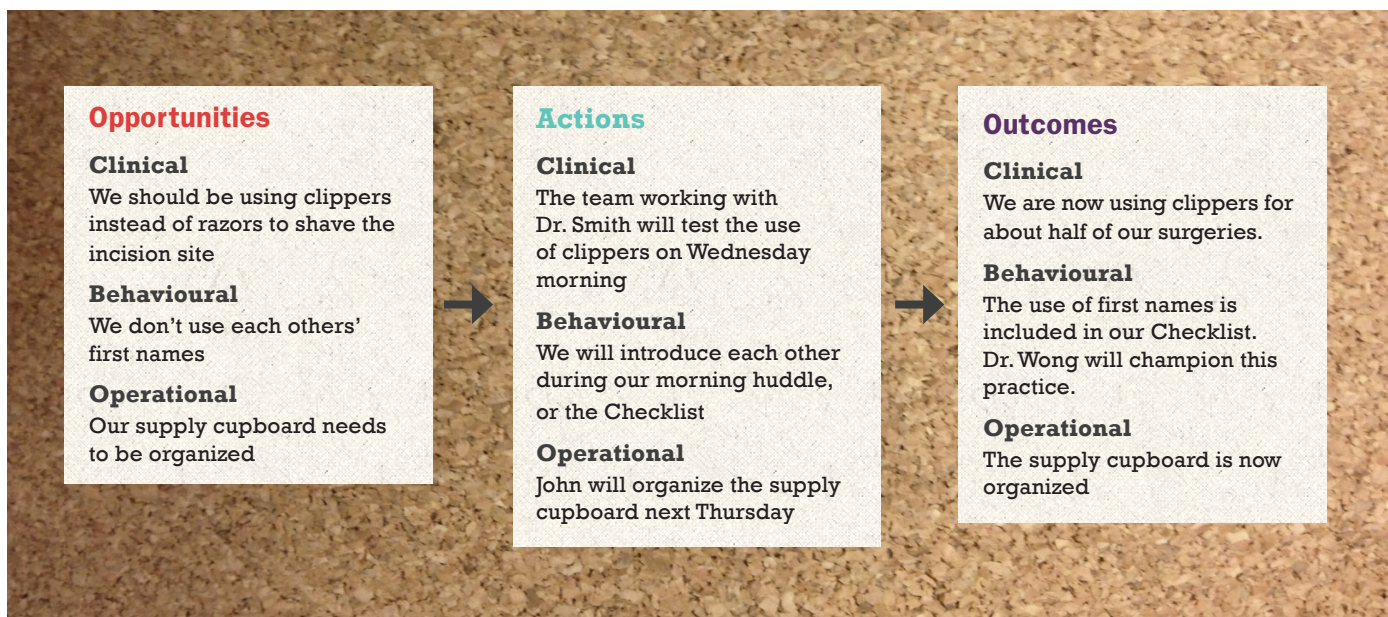
Leadership Walk Rounds⁴¹ is a specific form of visibility that refers to regular tours of all units or care areas by leadership. Leaders discuss safety and solicit feedback from staff. Be honest about what requests you can act upon, because once the process appears legitimate a flood of requests usually comes in. Download the [Quick Guide to Leadership Walk Rounds](#) from the Institute for Healthcare Improvement. This 5-page guide concisely explains the concept of Leadership Walk Rounds and provides examples of what senior leaders can say when they talk about safety.

Learning Board

IMPROVES:  SAFETY CLIMATE,  JOB SATISFACTION,  PERCEPTIONS OF MANAGEMENT,  WORKING CONDITIONS

A learning board is a visible mechanism for learning from past activity. A learning board is typically a poster board with three sections: opportunities, actions, and outcomes. The three sections are sometimes called “opportunities”, “in progress”, and “resolved”. Opportunities can be categorized as clinical, behavioural, and operational; but categories are not necessary. Actions refer to what is done in response to the opportunities, and outcomes refer to the end results of actions taken. A learning board visibly demonstrates that action is taken in response to input from team members.

- Learning boards are most powerful when any team member can freely submit an opportunity for change and all suggestions are displayed transparently.
- It is important to take appropriate action on all suggestions, or to be clear about expectations. For example, publicly pledge to work on one opportunity per month.



An example learning board.

Learning from Defects

IMPROVES:  SAFETY CLIMATE

When things don't go as we planned, it is important to learn from what happened in order to prevent future recurrences. Learning from defects directly promotes a positive safety culture, and it also signifies that safety is something we can talk about. We ask four questions: 1) What happened, 2) Why did it happen, 3) What did you do to reduce risk, and 4) How do you know risks were reduced.

1. Start by reviewing hypothetical or old cases in a classroom or meeting environment. This allows the team to become comfortable with the process of reviewing adverse events and talking about safety.
2. Once the team is comfortable with these discussions, introduce more recent events from your own work area.
3. When comfort with this process is high, learning from defects can take place as a quick discussion in the work area as a part of the normal work process.

Multidisciplinary Team Meetings

IMPROVES:  TEAMWORK CLIMATE,  JOB SATISFACTION

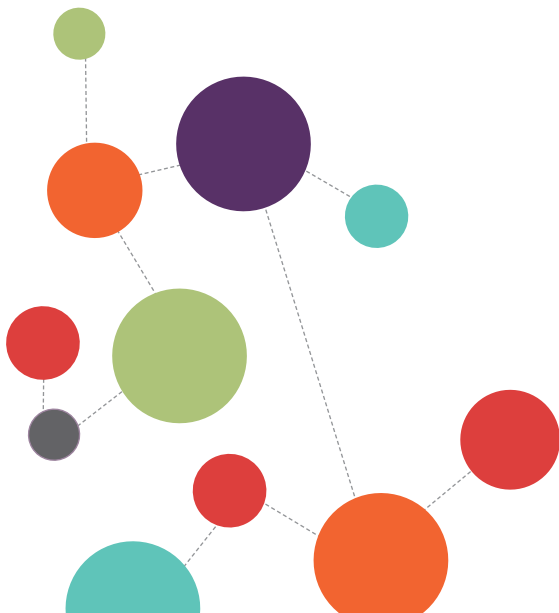
With busy schedules and different responsibilities, it can be hard to get all team members in the same place at the same time. Multidisciplinary team meetings provide a forum for all team members to develop a shared understanding of their work. They help to share information and perspectives.

1. To start, talk to everyone about the idea of having team meetings. Instituting team meetings without warning might make them seem top-down.
2. Have meetings with all members present. This is challenging, but try to find a time that works for everyone. Use supports like back-filling, starting the OR later, using grand rounds time if appropriate, and confirming management support. Look for barriers like time and location of meetings. Meetings that occur after hours may be a barrier.
3. Develop an agenda or structure for the meetings. Who will lead the discussion? Incorporate tools to help everyone speak up.

Roles and Expectations

IMPROVES:  TEAMWORK CLIMATE

Sometimes teamwork can be improved by a frank discussion of roles and responsibilities. Have each of your team members share his/her own vision of his/her role. It is important to have all team members present, and an outside facilitator might help.



Process Map

IMPROVES:  TEAMWORK CLIMATE

Process mapping is used to discover and record our real processes. **It's not about what we think we do, but what we actually do.** Process maps are created through group discussions that include everyone involved in performing the process. Having a map can show you where there are opportunities to improve the process by removing interruptions or waste. An additional benefit is that it forces all team members to come together and share their perspectives of the work, so it can be employed as a teamwork tool too.

1. Define the process. Is it the work of one nurse? Is it the path a patient takes through the unit? Where does it start and stop?
2. **Get everyone involved in executing the process in one room.** If the group is large, it is good to have a facilitator. If you are mapping the workflow of a large work area, it might make sense to gather a smaller group that is representative of everyone working there.
3. List all the steps in the process, and then put them in sequence. Listing all the steps on post-its is useful. Process maps are usually large; you can make them on chart paper.
4. Draw the flow between steps using arrows and other symbols.
5. You might add symbols indicating steps where a decision is required, where certain team members are needed, where information is involved, or where documentation is completed.
6. Review the map to look for opportunities to improve the process or change patterns of teamwork.
7. For more tips on process mapping, search YouTube. There are many videos available.

Safety Briefings

IMPROVES:  SAFETY CLIMATE

Safety briefings are regularly scheduled, short meetings to talk about safety. They are an important forum in which to address safety concerns, and their presence promotes a culture of safety. The steps below were adapted from the Institute for Healthcare Improvement.¹²

1. Identify a team or small group of staff that is willing to try something new. Host a test safety briefing one day during one shift with this group.
2. Start by explaining the purpose of the briefing: to discuss safety concerns of the past, present, and future. Emphasize that it is not punitive; it is not about blame. It is about increasing safety.
3. Think about some example issues to bring up at the first briefing. At first, it might not be clear to everyone what sort of topics they can bring up.
4. Keep it short. Five minutes is reasonable.
5. Thank everyone for their participation and be clear about next steps. Will someone follow up on the issues raised? Will there be another briefing? Will we make any changes to the structure of the briefing?
6. Adjust the structure of the briefing using this first group, then expand to have briefings more often or with more staff. Aim to include all team members eventually, and determine how often you would like to hold safety briefings in your work area.
7. Be transparent with follow-up. Share the outcomes of the briefing using emails, meetings, posters, or personal conversations. Acting on the information shared during safety briefings sends a powerful message that the briefings matter.
8. Once safety briefings are a regular occurrence, train other team members in hosting a briefing so that they can take place without the presence of the original facilitator.

Safety Champion

IMPROVES:  SAFETY CLIMATE

Safety is everyone's responsibility, but a safety champion is someone with expertise who can be a resource for everyone.¹³ Having a safety champion also symbolizes the importance of safety.

1. Anyone in your unit can be a safety champion. **It's more important to choose someone who volunteers** than someone who has a particular job title.
2. Give this person extra training on topics like the procedure for documenting safety issues, the science of safety (such as human factors), or quality improvement. The goal is for him/her to act as a resource for everyone else while promoting a non-punitive approach to safety.
3. Give the safety champion additional ability to act on safety concerns such as the authority to make certain types of changes to processes or allotted time during meetings.
4. Present the safety champion to the other team members as their ally. Ensure that the safety champion's role is truly non-punitive, to allow him/her to act as a resource to others.
5. The safety champion may be a member of an adverse event response team (see above).

Safety Reports at Shift Changes

IMPROVES:  SAFETY CLIMATE

Shift changes are a natural time to exchange information, so they are a great time to include a safety report. It also signals that information about safety is important to share. The steps below were adapted from the Institute for Healthcare Improvement.¹⁴

1. Start by identifying one team member or small group who is willing to test this.
2. Brainstorm together about what type of information is relevant to share during the safety report. You might just have one question, "Did you observe anything during your shift that is a safety concern?" If you are working on particular types of safety concerns, you might have specific questions. For example, "In this unit we are working to improve medication safety. Did you observe anything today that was a positive contribution to medication safety? Did you identify any opportunities for improvement?"
3. Develop a mechanism for submitting the information. Is it written down somewhere? Is it given verbally? Is it reviewed immediately or at the end of each day? How will those who submitted input receive feedback or follow-up? Is it anonymous or not?
4. At the end of a shift one day, perform a safety report with this small group. Use what you learn during this test to adjust the safety report for next time.
5. Once the process is working, increase the use of safety reports by incorporating additional team members and using safety reports frequently. Continue to adjust the process as needed.
6. **Take action or follow-up** on the input given during safety reports. This encourages the activity to continue and increases the quality of safety reports. If we know our input will go somewhere, we will take the time to give valuable feedback.
7. If safety reports are being performed at a unit, hospital, or system level, look for patterns in addition to addressing individual comments.

SBAR – Situation Background Assessment Recommendation

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

SBAR is a framework for communicating information. When all team members are consciously aware that they are using the same framework, communication is much easier for everyone involved. SBAR can be used in-person or over the phone, and it can also be used to structure forms. It can be applied to handoffs between units, at shift changes, during particular phone calls, or communications between team members (such as a nurse briefing a doctor on the condition of a patient).

SBAR has 4 components:¹⁵

- **Situation** What is the situation at hand?
- **Background** What is the relevant background information about the patient?
- **Assessment** What is your assessment of the situation?
- **Recommendation** What do you think should be done, or what is it that you need? What is the specific solution to the problem?

These materials outline the process for implementing SBAR (click each to view online):

[Worksheet](#) | [Guidelines](#) | [Quick overview of SBAR](#)

Team Vision Statement

IMPROVES:  TEAMWORK CLIMATE,  JOB SATISFACTION

A team is a group of people working collectively toward the same goal. In some cases it helps to articulate this goal and formulate a vision statement as a group. We may think that we have the same goal until we sit down to talk about it.

Two Challenge Rule

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

Sometimes when we raise a concern there is no response or nothing is done about it. When we don't receive a response our natural tendency is often to accept the non-response. However, when we're the one listening, we rarely get the message the first time. Most people need to hear something multiple times before it really sinks in. **Human nature is to say something only once, but it's also human nature not to listen the first time!** We can overcome this characteristic of human nature with the two-challenge rule:

If your initial request is not heard, speak up again. Assert your concern at least twice.¹⁶

If the speaker asserts their concern twice, it becomes the responsibility of the listener to respond. If they do not respond, the person with the concern should take it to someone with the ability to address the situation. Team members must therefore be empowered with the ability to act if someone isn't listening. Look at communication techniques like CUS words or critical language as ways to help team members halt activity.

Use First Names

IMPROVES:  TEAMWORK CLIMATE

Studies have found that teams whose members call each other by their first names perform better than those that don't. When people know each other's names, they are also more likely to speak up about a safety concern. Institute a defined time at the beginning of the day or procedure to introduce all team members. **When hierarchy exists, look for leaders in the "higher" group to model the behaviour.** For example, find a physician who is willing to insist upon the use of his/her first name.

Process Changes

Documentation

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

Communication occurs in person and on paper. **Revising documents can greatly improve communication overall.** Walk through your core documents as a multidisciplinary team. What does each field refer to? What does each team member need to know from each section of the form? How is each section interpreted by each team member? Think about how documentation is related to shift changes or patient transfers between units. Test a new version of a document before making it standard practice.

Handoffs

IMPROVES:  SAFETY CLIMATE,  TEAMWORK CLIMATE

When shift or care team changes occur, it is important to give extra attention to communication. In particular, it is helpful to create a formal structure for handoffs. Start by reviewing the current practice. What are the three key things people sometimes forget? What information is often missing? Focus on finding out what is actually happening, rather than what we think is happening.

To improve handoffs, we might:

- Create a structure to follow. ISBAR¹⁷ is a great framework for standardizing communication during handoffs.
- Create a checklist of points that must be discussed during handoffs. A checklist doesn't have to cover every detail; it focuses on the main points and the points often forgotten.
- Edit documentation to improve handoffs (see the section on "Documentation" above).

Limit Interruptions

IMPROVES:  STRESS RECOGNITION

If we reduce the number of interruptions we experience during our work day, we reduce the potential for miscommunication. The first step is to assess work flow, so we're looking at what we actually do rather than what we think we do. You can do this using process mapping (see above) or other LEAN techniques. There is a great guide to LEAN from the Institute for Healthcare Improvement.¹⁸ Your hospital might have existing staff or consultants trained in LEAN. Once you have identified the given steps in a process, look at which can be eliminated or where waste exists.

Here are some ideas to get you thinking about opportunities to remove interruptions and "waste:"¹⁹

- Are we doing something that isn't being used or isn't adding value? Something unnecessary?
- Are we duplicating?
- Do we have overkill?
- Are there intermediaries?
- Could we reduce the number of people involved?
- Are there any steps in our process that we can move closer together?
- Do we need to increase access to information?
- Is there a bottleneck?

Supervision and Training of New Personnel

IMPROVES:  WORKING CONDITIONS

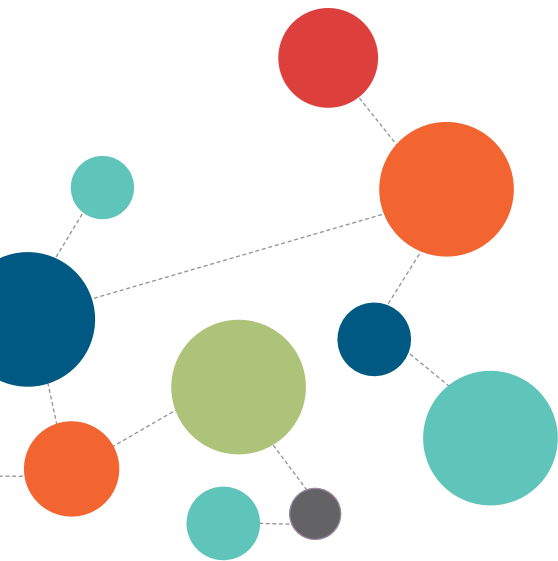
Proper supervision and training of new personnel is complex. If this is a concern in your unit, dig deeper. Ask both new personnel and long-standing team members for what they see as gaps in supervision and training. Ask if this concern refers to a particular group (e.g. residents, student nurses, or other students). For example, do our new nurses get trained on the equipment that we've had for ages or just the new machines? Is it technical skills that are lacking, or do they need orientation to the operational aspects of our workplace?

Training of Current Personnel

IMPROVES:  WORKING CONDITIONS

Having the skills to perform a task is an important contributor to safety. Current personnel may feel that they need more training in certain areas. If possible, address this in small steps. You might review a technique or skill every 3 months. For example, we might train everyone on the use of one particular piece of equipment such as an IV pump over the next 3 months.

Ask current team members what they would like to learn about. Use existing resources (like a nurse educator or human resources) to deliver the training. If you uncover consistent gaps in skills, look to deeper, systemic causes. Is this something we can work on with hiring and human resources? Is this feedback to give to those training students and interns?



Generate Ideas Locally

TRIZ

TRIZ is an acronym that stands for a Russian phrase “teoriya resheniya izobretatelskikh zadatch” which translates to “inventive theory of problem solving” (<http://en.wikipedia.org/wiki/TRIZ>). The basic idea behind TRIZ is that you put on a critical lens and **think about how to fail**.

1. If I wanted to ensure that I did not achieve my goal and completely failed, what would I do? For example, “If I want to fail in a course at school, I would never do my homework.” It can be really fun to brainstorm these hazards in a group!
2. Once you have a list of potential pitfalls, ask if any of these things are happening right now. For example, “Am I doing my homework regularly?”
3. Finally, look at how this list of potential and current pitfalls can be turned into ideas for improvement. Is there anything we can stop doing? Should we watch out for any hazards or obstacles? For example, “Can I start studying with a friend to encourage me to do my homework?”

25 Gets You 10

Have everyone anonymously write down an idea for improvement on a flashcard. Stand up and continue randomly passing the cards around the group until someone says stop. Read the card that you have in your hand at the moment and give the idea on the card a score out of 5. Repeat four times until each card has 5 scores out of 5. Have the last person to receive the card tally the scores for a total score out of 25. Ask the group if anyone has a card with an idea that received 25 points. 24 points? 23 points? Read the ideas with high scores out loud. **The team will own the ideas to start with and the changes should stick much more quickly and easier. Using the wisdom of the crowd can help amazing ideas to surface.**

5 Whys

The idea here is to **keep asking questions** that begin with “Why.” Why don’t we feel that our doctors and nurses work together as a well-coordinated team? Let’s say the answer has to do with communication. Why do we feel like communication between doctors and nurses could be improved? Why does it feel like we’re speaking a different language? Why do we use different terms when we mean the same thing? Why don’t we agree on some common terms to use? The more we ask, the closer we get to underlying causes and potential change ideas.

Positive Deviance

Most groups of people and even individuals exhibit variation, and this variation is a goldmine for thinking of ways to change your group’s practices and culture. For example, is there a nurse who tends to all the patients with time to spare, or a surgeon whose patients suffer fewer complications? We’re all in the same environment. We have the same resources and the same barriers, yet someone locally has found a way to be more efficient or provide higher quality. This person is a deviant in a positive sense, or a positive deviant. **Looking for positive deviants and studying their behaviour can uncover ways to change that fit with your local environment, because they were created organically in that environment! Is there a nurse who regularly voices safety concerns even when it’s difficult to do so?** Is there a manager in one of our neighbouring units or departments who is very effective at dealing with problem personnel? Seek out these positive deviants.

Testing and Implementing Change Ideas

Culture is made of attitudes and habits shared by a group of people. It's a dynamic, living entity. When changing culture, we try to go with the flow and go where the energy is.

People have to be engaged in culture change. Changes won't work as well if one person is doing all the work and making all the changes. **Talk to people about it like a broken record.** Talk about why it's important, using personal stories as well as facts. Select changes together, so everyone is behind the efforts. If our culture is changing, it really means that individual people are changing one at a time.

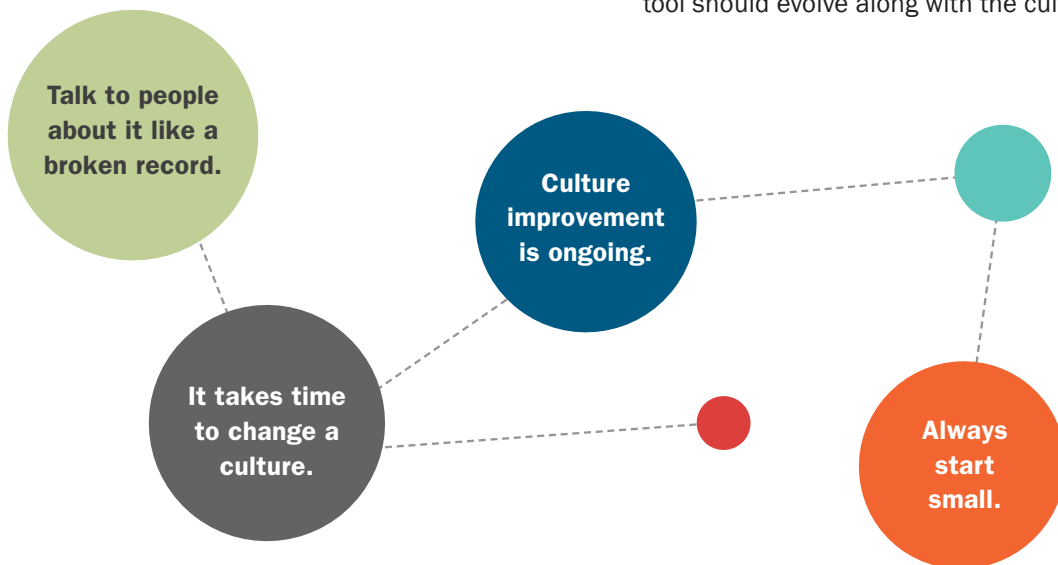
It's okay if emotions come up! Emotions can turn into action. Work with emotions that arise and think about how they can become fuel for change.

Think about who is leading the change. The best person to hold difficult conversations or introduce these tools is often a respected peer, who may be a formal leader or an informal leader. Aim for a multidisciplinary team.

It takes time to change a culture. There are no quick fixes. If something doesn't work the first time, adjust the idea slightly and try again. If there were easy solutions, they would have been tried already. The best approach is to take small steps in the desired direction, adjusting as you go.

Always start small. Test your intervention one time on one day with a small group of people who are willing to try something new. Using what you learn from that test, try it a second time on this small scale. Once the kinks are worked out, expand the practice or spread the tool. If something works, other people will try it.

A good culture requires regular maintenance, **so culture improvement is ongoing.** With any tool, small changes to optimize the tool are always required, as the use of the tool should evolve along with the culture.



Sharing data from the culture survey

Sharing the results of the culture survey is a powerful way to spark change and get others involved in change efforts. Here are some tips for sharing the results of the culture survey.

- It helps to preface the results with a reminder of the intent and purpose of the culture survey.
 - This is not about blaming one group or one person. This is about the way we work together.
 - Everyone comes to work meaning to do well and help patients. This is not about who is doing a bad job. This is about how we can all do better to help our patients.
- Will you share all the results or just the highlights? Some people have found it useful to send all the data to everyone via email. Others have chosen to share highlights in weekly meetings. Sharing all the data is best when people have time to look it over, and focusing on key findings is good when there is limited time for discussion. Overall, most people find it best to share just the main messages.
- A great way to share the results is to list the questions with the highest scores and the questions with the greatest room for improvement. It provides for a balanced discussion. When you are working on improvements, pick a high score to improve as well. Why is it OK to stop at 90%?
- Talk about components of culture that are good! When we focus on just the areas for improvement the conversation can become more negative than it has to be.
- Can the results be discussed in one large, multidisciplinary group, or will they be shared group by group? It may depend on when you have the opportunity to talk to different groups or disciplines. Think about how this changes the way you present the message.
- Who is the messenger? Will you have a surgeon talk to the surgeons, or do you want a neutral outsider to present the results? Having a front line staff member lead the sharing of results is very powerful.
- Will you use graphs? Sometimes a visual aid like a graph is very powerful. If you use graphs, ensure they are clear and simple. A few powerful graphs are more effective than dozens of graphs, as people can get lost when there are too many graphs.
- Do you need to provide additional information? Some people, especially information-focused people like physicians, will ask for more information. How was the survey conducted? How many people responded? What was the exact question? How do we compare to others? Think about what your audience might ask.
- If you are hosting a conversation or meeting, will you discuss the results as a large group or break into smaller groups? Groups of 8 or less are best.
- Employ different methods of dissemination: newsletter, whiteboard, email, verbal, staff meetings and daily huddles.
- Have a point person for this work, and acknowledge and support him/her. This allows the conversation to continue after any initial meeting or email blast.

Small tests of change

We're often used to implementing clear solutions and "fixing" problems. **However, culture change usually requires small changes over time, rather than a big change all at once.** Asking the following questions every time that we test a change can help us think in the mindset of small changes over time:

- What are we trying to accomplish?
- What change are we testing?
- What is our theory? What do we predict?
- How will we know the effect of the change?
- Are there any tasks we need to perform prior to the test? (Assign responsibilities)
- When will this test occur?

— Perform the Test —

- What did we learn? (Did our observations match our theory and predictions?)
- What actions do we need to take next?
- What should our next test be?
- Who can run the next test? Have more than just one person involved if possible. Group ownership is key.

Let's say that our test is going to be a safety briefing, a short meeting held regularly to talk about safety. Next Tuesday at 7:30AM we will discuss safety for 5 minutes with everyone on shift. The questions listed above are answered based on this example:

What are we trying to accomplish?

We want to see if it is possible to host a safety briefing.

What change are we testing?

We are hosting a safety briefing in the morning with everyone on shift.

What is our theory? What do we predict?

Our theory is that safety briefings will help people voice their thoughts about safety. We predict that people will take part in the briefing.

How will we know the effect of the change?

We will ask everyone who participates for their thoughts about the safety briefing.

Are there any tasks we need to perform prior to the test?

We need to ensure that the surgeon feels ready to host a safety briefing and that everyone will attend. The CNL is responsible for coordination.

When will this test occur?

It will occur (DD/MM/YY) at 7:30AM.

What did we learn?

People had a hard time speaking up. They weren't sure what they were expected to contribute.

What actions do we need to take next?

We will generate specific questions or a structure for the conversation. We need to think of an example to share so that people have an idea of what to contribute.

What should our next test be?

We will try this again next Tuesday using the specific questions, and the example if it is needed.

Endnotes

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For more information

**<http://bcpsqc.ca/clinical-improvement/teamwork>
or email nsqip@bcpsqc.ca**