


**Improving Implementation,  
Sustaining Culture**

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May 7, 2007*


**Improving Culture with RRS process-  
Why is this so hard?**

- We are asking different groups of people to do a number of things
  - Revise policies
  - Give up some responsibilities
  - Accept new responsibilities
  - Care for patients in a different way
- “Another bright idea that won’t fly....”
- Assault on pride: “I must be weak if I need to ask for help”
- Disturbs the Status Quo



**We have raised them very well**


- Nurses often have an intuitive feeling that something is wrong with the patient
  - Lack of confidence
  - Failure to persuade MD
  - May have been ridiculed
  - May have been demeaned
- Academia
- Layers and layers of red tape
  - Intern, resident, PA, ‘ask the surgeon’, ‘watch him and call me back’



**Top Ten Tips for Improving  
Implementation and Sustaining  
Culture**

**Realize - It is all about “Relationships”**

- Foster the relationships
  - Tell the stories, emphasizing each persons contribution
  - Find ways to get people together
- Survey tools
  - Safety Climate Survey
  - RRT survey – assign follow-up
- Confidence in clinical decisions
- Rapport with Physician
- Rapport with the patient and family



**Communication Matters**

- Standard communication tool can help every patient
- SBAR, or other communication tool can impact every patient
  - RRT Calls
  - Reports nurse to nurse
  - Any call to any physician
- Great tool for new nurses, they often are anxious about calling a physician
- Units can encourage use in fun ways



### Involve the Entire Hospital

- Educate and offer the RRT to all areas of the hospital
- Criteria must be familiar to the department
- Be sure and remember to include other departments in reporting and debriefing opportunities
- Explore opportunities to spread to the entire campus



### Staff get excited about some numbers

- Tell the Story every chance you get
  - > Monthly Newsletter
  - > Website corner
- Everyone can get excited about saving lives
- Use specific examples, People can relate
- Codes are memorable events, everyone wants to see less of them
- Post Weekly number of Calls and Data for entire hospital
- Process of identifying and improving system failures –is music to their ears
  - > Post Progress



### Recruit Family Involvement

- Families know the Patient Best
- Most Families want to help and need to be valuable
- Families often 'raise the red flag'
- Let them "call in the troops"
- Be sensitive to "Cues" - By responding to patients earlier, on occasion the family members may make another choice



### Follow-up is vital for sustaining change

- Follow-up with staff a few days after the event can enhance entire unit culture
  - Debriefings, utilize the documentation tool
  - Staff want to know what happened to their patient
  - Teachable moment using a real event
  - Encourage the rescue attempt
  - Encourages future calls



### Time (and consistency) heals all wounds

- Consistent, unquestioning responses by a RRT builds confidence in the nurses' assessment skills
- As confidence grows, patients will benefit
- Non-critical spirit encourage future calls
- Recruit calls
- Event follow-up



### Elimination of System Failure: Failure to Recognize


- Subtle Changes
  - VS, Change in LOC
  - Just don't look right
  - Cues from Families
  - Reluctance to "Raise the Flag" "Sound the Alarm"
- Improvement opportunities:
  - Education Plans
  - Non-judgmental debriefings
  - Skills labs, scenarios used in education opportunities
  - Documentation tools improvement



Elimination of System Failure: Failure to Communicate

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- Nurse to Nurse communication
  - Hand offs
- Nurse to MD communication
  - Inability to paint the picture for MD
  - Reluctance to call for help\Reluctance to demand help
  - Reluctance to utilize chain of command
  - Lack of Responsiveness of MD
- Improvement Opportunities
  - Inspect what you expect regarding hand-offs
  - Revisit chain of command in your facility
  - Utilize Systems in Place regarding MD response
  - Make it safe to call for help



Elimination of System Failure: Failure To Plan

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- Failure to Plan
  - Disposition changes, PACU patient
  - Lack of differential diagnosis
  - Missed diagnosis on admission
  - “Parking” ED patients,
  - Level of care issues, ED patient
  - ICU Beds in high demand, only the sickest patients get in
- Improvement Opportunities
  - Out the door assessment
  - Level of care safety net
  - Flow/triage alerts

