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Communication Matters

Appreciating culture

Call it synchronicity or coincidence: A number of recent conversations on seemingly disparate topics have each looped back to the importance of culture in the transformation of healthcare: implementing patient safety processes, aligning hospitals' and physicians' interests, measuring the impact of the patient-centered medical home model for primary care, and supporting the use of motivational interviewing-consistent skills in clinical practice.

In this issues of *Communication Matters* we explore the promise (and limitations) of safety checklists, and the vital role that organizational culture plays in patient safety.

Warmly,

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Like gravity or oxygen, culture is invisible, yet its effects are pervasive. Organizational culture encompasses the full range of human behaviors and interactions; values, beliefs and norms; and systems, habits, rituals and language. **Culture has particular significance for organizations facing pressures to change, and it is hard to think of a field where there has been more recent change than healthcare!** An organization that embraces change and supports its members' efforts to do things in new and more effective ways will be better poised to roll with-and even thrive-amidst the onslaught of pressures for change.

Patient safety checklists

The implementation of patient safety checklists provides an illustrative example of specific steps that have been associated with positive results. The 2006 report of interventions used to reduce catheter-borne infections among ICU patients as part of the Michigan Keystone ICU program (Pronovost 2006) was "widely reported in the popular media and elsewhere as a triumph of the "simple checklist" as a solution to patients' safety problems." (Bosk 2009)

A partial list of the steps involved in the technical approach to safety checklists includes:

- identifying safety issues
- analyzing root causes
- evaluating the evidence for possible interventions
- establishing processes for improvement and measuring outcomes

These elements of the technical solution are relatively easily adopted; however, without addressing the adaptive challenges, replication efforts have shown disappointing results. Bosk outlines the social and cultural aspects of safety checklists that can impede their adoption and efficacy: Clinicians may feel checklists undermine their decision-making speed and authority, discount their expertise and risk reducing their practice to "cookbook medicine." Clinicians' feelings can result in resistance to and interference in the adoption of safety checklists.

> The mistake of the "simple checklist" story is in the assumption that a technical solution checklists can solve an adaptive (sociocultural) problem (Bosk 2009).

Based on early research that showed positive patient health outcomes with the use of safety checklists, the province of Ontario's health authority mandated the use of surgical checklists. That this mandate "was not associated with significant reductions in operative mortality or complications" (Urbach 2014) raises important questions. Was the research methodology flawed? Were the checklists inadequately implemented? Might the results have been different with team-specific (instead of World Health Organization-developed) checklists? Did the use of checklists result in staff members becoming less attentive? Is there something about mandating checklists that engenders less-than-optimal adoption?

Why isn't the evidence for the efficacy of safety checklists consistently strong?

One possible explanation is that an overly simplified approach that focuses on the technical fixes without due attention to the adaptive aspects can have limited impact at best. Bosk and co-authors, as part of their critique of the oversimplification of research findings describing the use of patient checklists to reduce infections, outline the substantial adaptive work conducted by the Michigan Keystone ICU program:

> Emphasising checklists as the explanatory mechanism for the reduction in catheter-related infections obscures the complex labour necessary to create a collective local faith in checklists. How support was mobilised for coordinating work around infection control is the real story of the Keystone ICU project ... What happened in Michigan involved the creation of social networks with a shared sense of mission .... Implementing the entire programme occurred over 9 months-it was not simply the case that the units were handed the checklist and immediately fell in line. The work was arduous ... each hospital had to assign a senior executive to work with participating units and [e]ach ICU was required to identify a physician and nurse team leader. The executives were required to meet monthly with unit workers, listen to problems, and work with team members to solve them. Team leaders received instruction in the science of safety as well as each component of the comprehensive intervention ... The checklists were thus themselves just one component of a more comprehensive programme to alter the culture of the ICUs,

which included, among other things, empowering nurses to stop procedures if guidelines were not followed (Bosk 2009).

The substantial effort around implementing checklists-the planning, training, accountability structures and mindset, support for ongoing communication, etc.-does not occur on its own. There must be strong leadership support for care teams to devote the time to make this-or any- innovation work. In this light, the checklist itself is just a small part of the picture. Peter Pronovost, MD, PhD, FCCM and Director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins, writes about hospital-acquired infections, that:

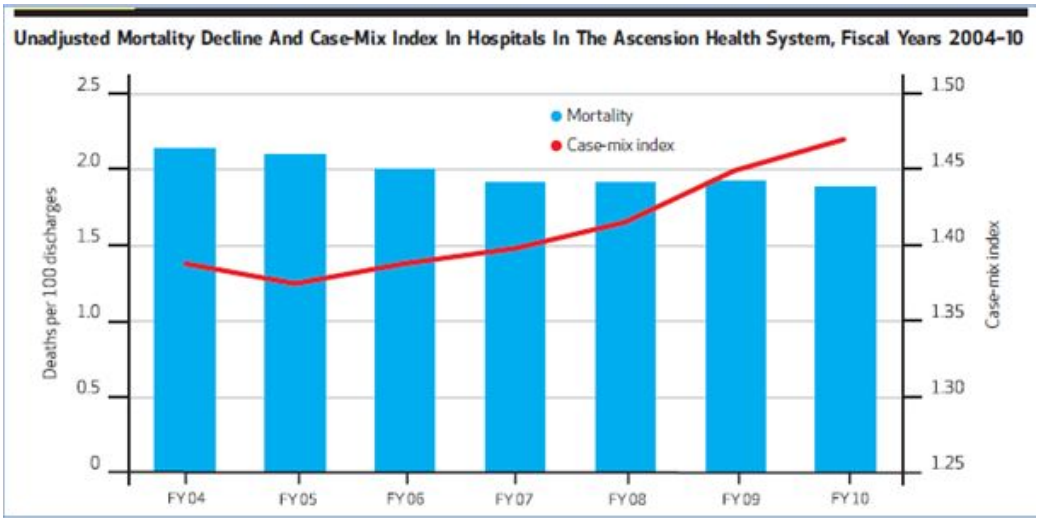
> "there is no quick fix... It's not about the checklist, but about continually improving how we work..." (Pronovost 2014).

Another way of thinking of this is that **checklists should not be equated with patient safety**. Radiologist and blogger Saurabh Jha, MD summarizes this succinctly:

> It's important not to confuse the directionality. Vigilance produces checklists. Checklists alone do not produce a culture of vigilance (Jha 2014).

Ascending the improvement curve

When an organization's culture is focused on improvement and its management commits sufficient resources to implement positive changes, significant and far-reaching results are possible. **Ascension Health**, the largest Catholic health system in the US (and a longstanding IHC partner), describes its multi-site, multi-year initiative to decrease preventable deaths among hospitalized patients. Among its many impressive results were a larger-than-expected reduction in mortality, and a decline in the mortality rate despite an increase in the severity of illness of hospitalized patients



A 2011 article in *Health Affairs* describes Ascension's safety initiatives in detail. One of the key discussion points is:

The emphasis is on creating a teamwork safety culture in how we work, so that the inevitable mistakes that we make as individuals will not result in harm to a patient (Pryor 2011).

Ascension's patient safety improvements were enabled by the availability of electronic health records, research capacity, training capacity and requirements, outcome reporting infrastructure and more. The intangible ingredients include: shared quality goals among all members of the organization, a commitment to improvement, ongoing investment in

the change process, integration of quality improvement efforts with governance and operations and active involvement of caregivers in the design of improvements.

In a discussion of the challenges of ensuring patient safety in healthcare, Amalberti discusses the benefits and limitations of importing established strategies for high reliability performance from other industries into healthcare.

The most important difference among industries lies not so much in the pertinent safety toolkit, which is similar for most industries, but in an industry's willingness to abandon historical and cultural precedents and beliefs that are linked to performance and autonomy, in a constant drive toward a culture of safety (Amalberti 2005).

Multifaceted approaches drive progress

The complexity of healthcare, the pace and scope of pressures for change, and the significance of cultural dynamics in health services underscore the value of considering the adaptive aspects of care improvement, along with the technical aspects. The first challenge for healthcare organizations-as for healthcare workers-is to develop self-awareness:

> *Where are we now?*
> *Where do we want to be?*
> *How do we get from here to there?*

For individual providers, self-awareness, strong communication skills and effective self-care can rekindle and sustain the joy of the helping professions. Kathleen Bonvicini, IHC's CEO, and Monica Broome, IHC Master Trainer, will be leading a workshop May 30 at the 1st International Meeting on Wellbeing and Performance in Clinical Practice in Alexandroupolis, Greece, "Compassion fatigue: Caring until it hurts in veterinary practice."

Healthcare organizations-in human and veterinary medicine-are increasingly discovering the central role that communication plays in actualizing and sustaining improvements. IHC is privileged to work with some of the most outstanding healthcare providers in North America. We have seen how healthcare organizations that bring together the tools and the attitude to make positive changes can set in motion significant, measurable and sustained improvements in patient safety and satisfaction. To learn more about how IHC's communication skills training curricula can animate quality improvement initiatives in your organization, visit IHC's website or contact us at info@healthcarecomm.org.

Notes

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Faculty development course for IHC's flagship Clinician-Patient Communication workshop

IHC's flagship curriculum, Clinician-Patient Communication to Enhance Health Outcomes (CPC) is designed for clinicians at any stage of their careers. Healthcare organizations across North America have not only trained clinicians in enhanced communication skills, they have also built their in-house training capacity to support sustainable enhancements in clinicians' communication skills.

Applications are now being accepted for prospective clinician trainers to join the **September 9-12, 2014** CPC faculty development course, hosted by **The Southeast Permanent Medical Group, Atlanta, GA**.

Additional upcoming courses are listed on the IHC website.

IHC is nationally accredited to provide continuing medical education and continuing nursing education by three major accreditation agencies (ACCME, AAFP, and ANCC). IHC takes responsibility for the content, quality and scientific integrity of all its CME/CE activities.

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