SUCCESS COMES FROM HAVING THE PROPER AIM AS WELL AS THE RIGHT AMMUNITION

From Common Sense To Health Cents

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Meeting Patient Requirements Through Quality

Healthcare quality is on the national agenda. Despite two decades of efforts and significant expenditures, our industry continues to struggle with meeting consumer expectations and rebuilding consumer confidence. If healthcare organizations are to achieve success in this area, they first need to assess their own attitudes about healthcare quality initiatives.

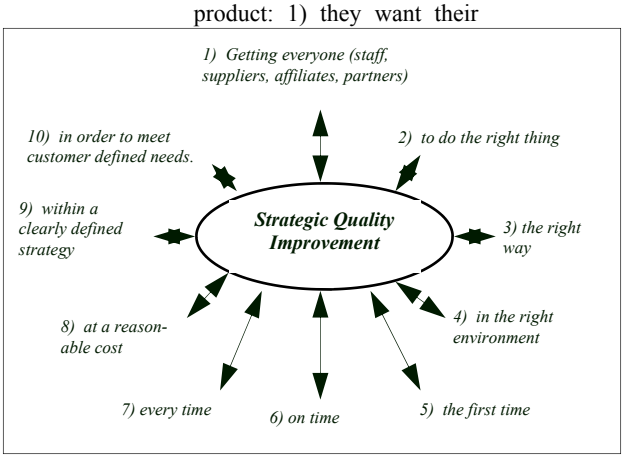
There are four very important realities that must serve as the foundation for what we do. These are:

1. *Quality improvement is not a task; it is a way of life. Successful organizations are those where the concern for patient and community perception is the hallmark of all their activities.* For quality improvement to be effective and make a difference in an organization, it must be pervasive. It must be part of every conversation, a consideration in every action and an accepted, comfortable way of life for all employees and business associates. The goal is the get everyone 1) to do the right thing; 2) in the right way; 3) in the right environment; 4) the first time; 5) on time; 6) every time; 7) at a reasonable cost; 8) within a defined strategy; 9) in order to meet patient defined needs. Meeting customer defined needs is where many organizations fall down. In many of the industry's existing programs, providers define what quality looks like and then create the illusion that that is what the patient wants. This difference in perceptions creates discord between providers and patients.
2. *Quality is about connecting with those we serve. The challenge in health care is that we have multiple customers.* Kevin Miller points out in his work that customers are looking for two things when they judge a service or product: 1) they want their problem fixed or their needs to be met, and 2) they want the provider to make them happy while that need is being met. In healthcare, patients want us to help them achieve the optimum level of health possible for their physical condition and they want to feel good about the experience. They want to have trust in their providers and a general sense of control over their own lives. Healthcare providers who connect with their patients have a uniquely collaborative relationship that provides a general sense of satisfaction. Whether that customer is a patient, the state health department, an insurance company, or an accrediting agency, the goal is the same; to meet their needs and make them feel good about it.
3. *The perception of quality is not black and white as quality is defined in the eye of the beholder and often a measure of perception.* One of the greatest challenges in meeting patient needs and making them happy at the same time lies in accommodating the uniqueness that each customer brings to the relationship. The challenge is to avoid the fragmentation that each customers' different needs can create as this fragmentation often results in declining quality.

   Most healthcare programs are designed for the average patient and consistency. Dave Schulenburg points out that customers feel variations, not averages. It is the variations that tend to get healthcare providers in trouble. As patient perception is created within the context of their experiences and influenced by their values, goals and personality, the challenge can seem impossible to achieve. The ability to create the correct value propositions in the shadow of all these variables demands quality improvement programs that promote greater flexibility and a much higher level of interaction.
4. *The perceptions of the patient and community are a healthcare provider's realities.*

   Healthcare has historically enjoyed the privilege of defining what good health care looked like and expected people to simply accept it. Today's patient wants control of the decision between good and bad care. Successful providers are those that strive for those uniquely collaborative relationships that honor this need.

   If a provider elects to ignore patient perception, the provider also elects to place the patient/provider relationship at risk. Patient loyalty is not what it once was. Each action or decision carries a series of positive and negative consequences and they are reality for an organization. Today's society has little patience or sympathy for self-proclaimed victims.

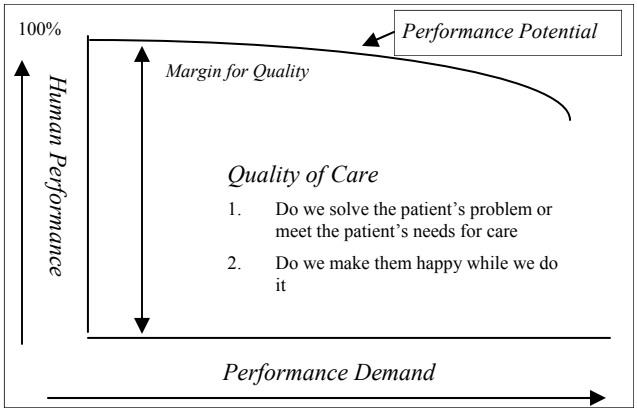


INSIDE THIS ISSUE:

"COMMON SENSE IS SEEING THINGS AS THEY ARE, AND DOING THINGS AS THEY OUGHT TO BE DONE"

Achieving the Right Focus; Understanding the "Context" in Which Errors Occur

Many of our past initiatives have failed because the implementation too often involved immediately jumping into quality tactics without a clear strategy or a clear understanding of how to achieve the desired outcome. Because of this, employees in many healthcare organizations have come to see quality activities as nothing more than one additional way for them to work harder.



Important to the strategy for quality improvement is making sure we have the right focus. Many healthcare quality initiatives focus on the errors themselves not on the context and confounding variables that create the environment that allows the errors to occur. The "context" is the interrelated set of conditions in which patient care is delivered or support activities occur.

The industry's continuous struggle to create a sustainable quality initiative and to combat declining employee morale is largely impacted by the fact that many of our programs and techniques have the wrong focus; they focus on the error (or more commonly the person) and not the context. Today's programs also tend to attribute errors to an isolated cause when, in reality, the error is often the result of a number of variables all coming together to create an error-ready environment.

As was discussed earlier, patients define quality by looking for two key questions to be answered: 1) "Can the provider solve my problem or meet my needs to have my health-related condition adequately addressed" and 2) can the healthcare provider make me happy while meeting that need". The Sigma Six approach to performance improvement refers to these as the "patient's requirements". The two most critical factors that impact a healthcare provider's ability to meet those two requirements are human performance and performance demand.

Human performance is a measure of a healthcare worker's ability to perform the skills, both clinical and interpersonal, to meet the patient's requirements. From a clinical skill perspective, the patient is concerned with whether the healthcare worker has the training necessary for the role they are in, is educated as to the most current recommendations and techniques, and whether that individual can apply all that knowledge and skill in an appropriate and safe manner. On the interpersonal side, the patient cares whether the healthcare worker can be respectful of his or her social and religious views along with the values that make the patient who he or she is.

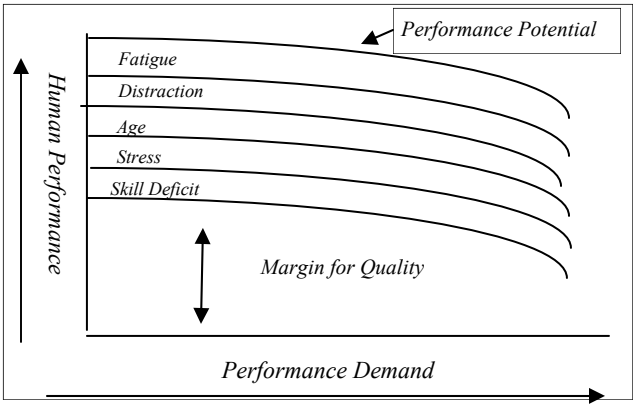
The patient's perception of our interpersonal skills plays an important role in the opinions he or she develops and its importance goes up as the patient's ability to judge the clinical side of our skills goes down. It is commonplace for patients to use factors such as timeliness, courtesy, appearance and acts of caring as measures of clinical ability. This is largely due to their need to justify their choice in healthcare providers and these are measures they can understand.

Performance demand is a reflection of the demands on a healthcare professional's time and abilities while striving to meet that patient's requirements. Performance demand is largely defined by the system within which the health professional works. It is reflective of variables such as patient assignment and the environment in which care is delivered. Performance demand can be impacted by variables that are either constant or intermittent. For example, a decision to downsize creates a context in which there is a constant impact on the performance demand for those employees that remain with the organization. Intermittent performance demands occur as a result of outside forces or variations in routine processes and create some sort of short term increase in demand.

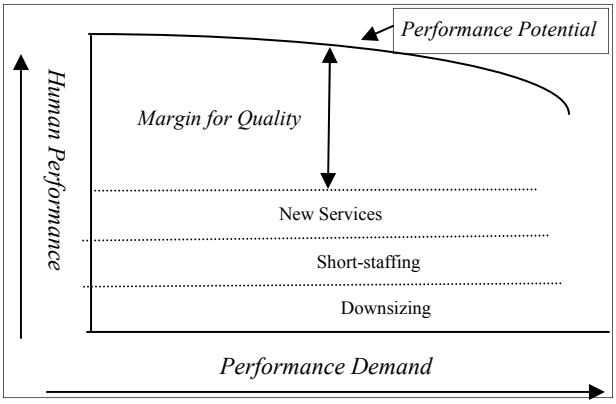
Understanding how these two sets of variables impact the margin for quality is how we evaluate the context in which an error has or can occurred. Better understanding the context of how care is delivered is how we move from reactive to proactive quality improvement. Once we are able to develop a realistic picture of the context in which care is delivered, we have the potential to proactively improve care and minimize the potential for error by proactively managing that context.

Important to this process is a clear understanding and acceptance that errors are going to happen. Our employees are not perfect and no matter how much we demand perfection, errors will occur. The effectiveness of a quality improvement program is twofold: 1) to minimize the potential for the 3-5% of errors that actually cause harm so that the potential for their occurrence is as close to zero as is possible, and 2) to continuously be identifying opportunities to improve the context in which care is delivered so that patients feel their requirements are being met and exceeded.

The goal of exceeding their requirements is critically important in today's environment because this is how our industry will regain the trust of our communities. In today's environment of growing competition, more informed consumers and skepticism, it is not enough to do our best. We must make sure we do it right and that we do it right the first time. Patients don't get any warm, fuzzy feelings from providers that focus on simply meeting the basic requirements. Organizations whose quality programs set their standards at the level of regulatory compliance are organizations that struggle in creating warm, fuzzy feelings as regulations are nothing more than the basic expectations of a healthcare organization in protecting the safety of its community.



Understanding and managing the context in which care is delivered involves understanding the numerous variables that impact the delivery and creating system to control for them. While we may not be able to totally negate the variables, having systems to minimize their potential for negative outcomes becomes critically important. This also allows us to move away from the disciplinary and punitive approaches that are driving healthcare professionals away from the industry and driving staff morale to an all time low.

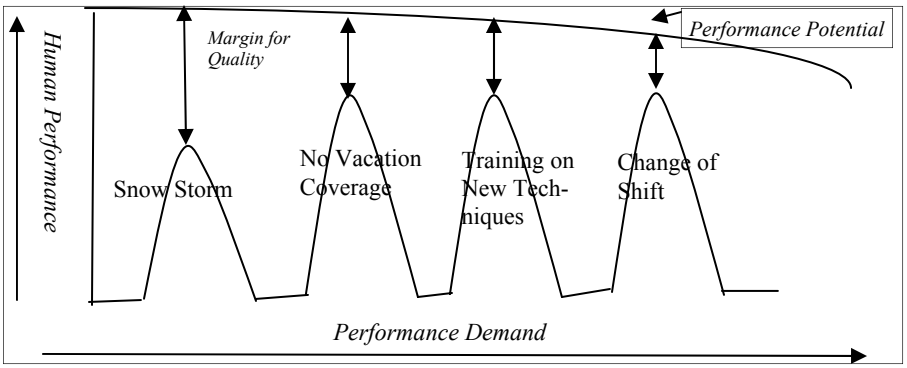


As performance demand goes up, it creates a strain on human performance and there is a natural tendency for there to be some level of decline in human performance. The magnitude of that decline is impacted by two primary variables: 1) the size of the increase in performance demand, and 2) the number and significance of the confounding variables creating pressure on human performance. As both of these increase in number, size, and significance, the margin for quality shrinks and the potential for error increases. As the margin for quality shrinks and the potential for error increases, the likelihood for an error that causes harm increases exponentially. Studies have shown that when an employee is under stress while he or she is performing an activity for which he or she was adequately trained, the potential for error goes up fourfold.

Factors that can impact human performance are things such as stress, distractions, age, multi-tasking, fatigue and skill deficits. A good example of this comes out of the airline industry where some carriers have a policy that pilots are temporarily removed from flying when significant, life altering events occur in their lives. This is not because the individual is a poor pilot but because there is a recognition that that event is likely to create stresses and distractions that may reduce the pilot's ability to remain focused. To protect both the pilot and customers, the airline gives the pilot a timeout period.

Healthcare has limited systems for these types of protections. How likely is it for a hospital to tell a cardiac surgeon that he or she can't perform open heart surgery until they have had a timeout. But when that surgeon, with a stellar reputation, makes an error after trying to function on the heels of a life-altering event, it becomes a sentinel event. Then everybody and anybody wants to evaluate the individual. Suddenly the question is whether he or she is a competent professional.

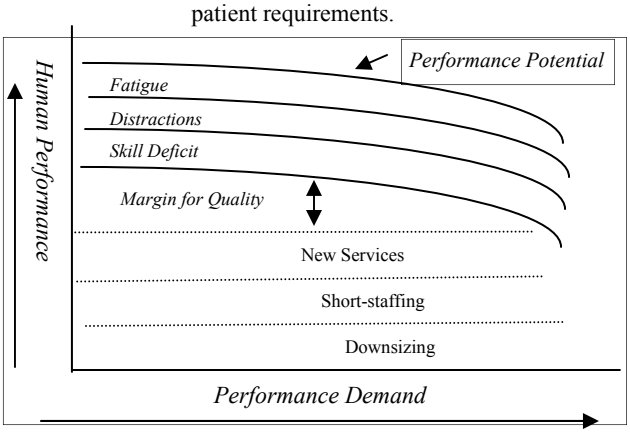
The changes in the healthcare industry over the past two decades have created numerous stresses for our healthcare workers. Many of these stresses and distractions have never been fully resolved and are having a compounding effect on our workforce. As all these variables compound, they negatively impact human performance. As a result, healthcare workers are looking outside the traditional areas of the industry for opportunities where they can experience a sense of high human performance, growth and a feeling of self-worth.



Increases in performance demands come in many shapes and sizes. Some are very obvious and some are insidious. While being the champion for quality improvement is a critical role for management, the second important role is managing performance demands. Important questions in this process are: have we helped our staff to develop the skills necessary to meet patient requirements; have we given the staff the right equipment to perform the task; can we realistically expect more from the existing workforce; do we have the right processes in place to promote efficiency and effectiveness, what are our danger zones where the nature of the necessary activities reduces the margin for quality and how do we implement change while minimizing the increase in performance demand.

Due to the economic pressures and the technological boom of the last two decades, healthcare has significantly increased the performance demands on its professional staff. New drugs come on the market so fast it is impossible for any one person to learn how to achieve the maximum potential of all of them. New computerized equipment increases the demand for computer expertise. Medical breakthroughs change the way care is delivered almost daily. Too often, in the rapid pace of today's environment, we forget to stop and evaluate the impact on the people who have to make it work.

When you bring together all the variables that impact human performance and performance demand, it is easy to understand how we can end up with very small margins for quality and high potentials for error. Successful quality improvement programs work to create strong margins for quality which in turn position our workers to meet patient requirements.



Creating a Culture for Quality

Every organization has a set of values and a culture that defines the organization and how it conducts business. One of the most common mistakes made in quality management activities is to ignore that culture and assume that the employees will simply step up to the plate and do what must be done. As quality improvement activities usually involve the creation of change and culture tends to treat change as the main course for lunch and new initiatives as the main course for dinner, understanding the culture of an organization is critically important to managing the context in which care is delivered.

All employees and organizations have a set of values and beliefs that dictate how they act and how they react. A value is an enduring belief that a specific mode of conduct is personally or socially preferable to an opposite or converse mode of conduct. This enduring set of beliefs determines the behaviors that both individuals and organizations consider to be appropriate and inappropriate and determines the norms or standards of conduct within organizations.

The culture is best defined as (1) a pattern of basic assumptions, (2) invented, discovered, or developed by a given group, (3) as it learns to cope with its problems of external adaptation and internal integration, (4) that has worked well enough to be considered valid and, therefore, (5) is taught to new members as the (6) correct way to perceive, think, and feel. The culture reflects the workforce's learned or developed way of coping with its environment .

These values and cultural norms define the organization's heroes, rites, rituals, standards of conduct (both formal and informal) and taboos. If the focus of a quality initiative or activity challenges any of these values or cultural norms, the plan has a much greater potential for failure if the plan does not include a set of actions to change or accommodate these values and the culture.

Cultural norms and values are very difficult to change, even when it is obvious that they are no longer in the best interest of survival. This is because there is a sense of security and control within the safety of their bounds. Value-related behaviors are often the most difficult to change as they are tied to a belief system of what is right and wrong.

Managing the cultural belief system of a healthcare organization is critically important, particularly in today's market. Staff in many organizations are victim of "change fatigue" and "quality fatigue". The quality improvement programs of organizations where fatigue is high are the main course for cultures in these organizations. Employees have grown tired of what they view as hollow promises that life will get better. They view quality as something that was foisted on the workforce as something extra to be done after they finish working double shifts and sacrificing their lunch breaks and days off. They have no confidence in the phrase "this will make things easier".

In working within the context of an organization's culture, it is important to understand that the majority of employee do want the benefits that come with positive results. They just don't what to make the trip to get there. This is usually the by-product of too many previously unpleasant trips that did not produce positive results or add value. Those previous trips also frequently resulted in activities that violate a cultural belief or value. For example, many of our past quality initiatives have created mountains of forms and paperwork that keep healthcare professionals behind a desk and take them away from the patient. Most healthcare workers chose healthcare as their career path because they wanted to be at the bedside helping others. The fact that most of our quality monitoring initiatives are also paper-based increases the sense that the activities violate what healthcare is about.

The challenge for healthcare organizations is that their employees' perceptions are the organization's reality. If that perception is negative, the organization's ability to gain the level of support and commitment for quality initiatives is in danger. A successful quality improvement program must recognize these dangers, be responsive to them and create positive outcomes that allow employees to develop a personal desire to engage in the needed change.

Change is critical to an organization's ability to sustain a successful future and should not be abandoned for preservation of historical values and culture. The culture of the past needs to be replaced with a new set of basic assumptions that can help the staff to cope with its problems of external adaptation and internal integration. These new assumptions can then be taught to new members as the correct way to perceive, think and feel. This new culture must protect those cultural assumptions that are critical to quality patient care and create new values and beliefs that improve on the past. Only then will employees be willing to give up the old way of thinking, perceiving and feeling. Once an organization has achieved this, the employees can more willingly move from the past into the future using quality improvement as the way to get there.

Quality Improvement's Role in Creating Patient Value Propositions

Whether a patient chooses to use a particular healthcare provider is based on the value proposition that the patient believes to be true about that provider. Value propositions are defined by the patient or community and are those features of the organization's services that they determine as meeting their needs the best and thus, make the organization and its services the preferred choice. Successful value propositions are validated in the mind of the patients and community based on their observations, experiences and their perception about the context in which they receive care.

Critical to understanding a patient's value proposition is accepting that their perception is a healthcare provider's reality. The only solution to a perceptual deficient is to improve the perception. With it estimated that 30% of a small rural hospital's potential patient base is by-passing them and 40% of an average physician's patient base is at risk of being enticed away by stronger value propositions, healthcare providers need to be very conscious of value propositions.

Too often, negative perceptions are related to beliefs of compromised quality. This is particularly challenging for small and rural providers when the healthcare provider is often a focus of attention for the community. As one doctor in a small community once said, "People never remember the 99 cases where you did a great job but they talk forever about the one where outcomes were poor. Too often, you have to wait for an entire generation to pass on before you have the potential for it to be forgotten and that only occurs if it has not become a community legend."

Quality improvement activities need to help dissect existing value propositions to better understand how to further develop them, to minimize the potential for dangerous tinkering, and to improve problematic perceptions.

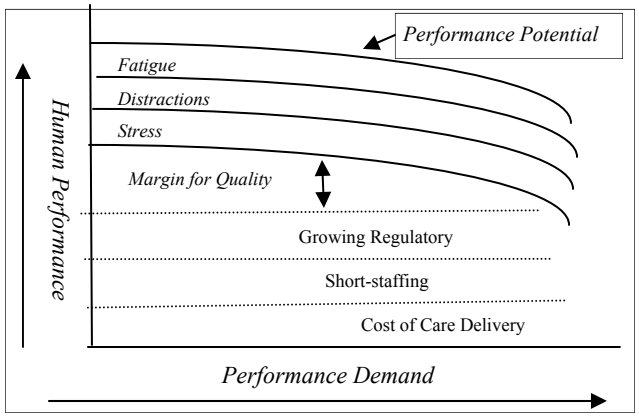
Leadership's Role in Quality

Over the past two decades, health care has seen a number of quality iniatives. Experts who have evaluated the American quality movement in many industries have sighted the lack of leadership's involvement and support as one of the principle reasons for failure. The healthcare industry has felt the impact of this where leaders have viewed quality initiatives as a necessary cost related to regulatory compliance instead of a critical activity for protecting and promoting stronger business.

Unlike most industries that jumped into the quality movement if the 1980's because they saw it as important to creating a competitive edge, healthcare found itself in the throws of the quality movement because of federal and state regulatory requirements and expectations of accrediting agencies. The industry was on the tail-end of the era where regulators protected the markets of healthcare organizations through certificates of need requirements and similar processes. Most hospitals had never had to think about protecting their market share and many of the threats that other industries had to worry about and control for. Since quality was part of a marketing hype, the question was why should healthcare organizations have to worry about it. At that time, health care also enjoyed a reputation of being special and different so there was an attitude that whatever applied in general corporate America could not work in health care and probably didn't apply.

These attitudes of the 1980's created the foundation for the struggles we face today. Many of our quality improvement programs are built on the goals of pleasing some outside entity such a CMS and JCAHO. While these organizations are critically important customers to any hospital or nursing home, the reality is that they are not our primary customers and their expectations are not necessarily the same as patient requirements. The fact is that organizations that have very strong patient focused programs that exceed the minimal requirements established by regulation usually find themselves automatically in good standing with these outside agencies as a by-product of their efforts.

The failure to have patient-focused programs leads to responses from these outside agencies such as those we see today. Regulatory and accrediting agencies promote higher quality through special initiatives, stronger regulations, greater oversight, and harsher punishments. Despite these types of efforts in the 1990's, the value propositions of the American population are not improving. This is largely due to the same compression problem discussed on previous pages but the issues are at a macro level. The only solution is for healthcare organizations to take control of their quality initiatives and make them what they need to be. No one can save our healthcare organizations but the organizations themselves. Leadership is the key to that future.



If you look at the current performance improvement methods that are the "hot" topics in healthcare, they all stress the importance of leadership. The Sigma Six model openly talks about how critically important it is to get leadership on board before anyone else in the organization has the potential to be successful. The authors of the Balanced Scorecard point out that there is little to no potential for strategic success without a focus on creating strong leadership. In their book, Zenger and Folkman talk about the key role of leadership in creating high level performance.

The reality is that leadership either breaks or sets the glass ceiling for the performance of everyone in the organization. Thus, leadership's ability to embrace a personal commitment to quality allows everyone else in the organization to achieve a comfort level with it. Too often, employees perceive that leadership talks the talk but does not walk the walk. Until there is a clear message that leadership walks the walk every day, employees are not going to take the risks necessary to create change and expend the energy necessary to make that change happen. One of the most difficult and sometimes humbling experiences for healthcare leaders is to understand that the perception of their employees is their reality. If the leader believes he or she champions quality but the staff perceive differently, then the leader needs to evaluate what creates that negative perception and change.

As leadership teams analyze what they need to do differently to achieve the desired perception in the eyes of their employees and community, it is important to recognize that these needs will vary from leader to leader and from level of leadership to level. While all leaders need to have strong skills in championing and communicating quality, the focus of the skills may vary. The CEO needs to champion quality from an organization-wide perspective and clearly link that commitment to mission, vision and strategy. Senior managers need to be able to translate that into how-to activities from a division level without losing any momentum. Frontline managers need to operationalize it in day-to-day activities while maintaining the same level of enthusiasm and commitment.

In today's environment, leadership faces numerous barrier to success based on history and current pressures. Leadership development has never been more important than it is today. Our traditional approach to building management teams has been to promote best performers. Many of our healthcare managers are people who are or were technically good. We throw them headlong into a mangerial role and hope their ability to excel continues. What we forget is that they had training to gain a foundation on which to build that technical ability and that training probably didn't include anything on leading. Managing and leading are entirely different skill sets from clinical performance. Weaknesses in the ability to lead and manage set managers up to fail in the worst case and set glass ceilings for their department in the best case. As a result, the organization fails or stops growing significantly below its potential. These limitations have the same impact on an organization's quality initiatives.

Attack Problems, Not People

Looking at the impact of confounding variables on human performance

Case Study #1 A unit secretary who had been an employee of Happyville Nursing Home for 8 years was having errors in her transcription of physician orders. Despite progressive disciplinary efforts, her error rate continued and increased. She had received verbal counseling, two written warnings, attended a transcription refresher course and been suspended for three days. The Director of Nursing decided that her continued "noncompliance" left the Nursing Home with no choice but to terminate her.

As part of the pre-termination process, the Director of Nursing had the organization's contracted risk management consultant review the employee's discipline record to validate the completeness of the disciplinary process. In her review, the consultant found two disturbing variations. Prior to the past four months, this employee had been praised as an employee that excelled at her job and had actually received two internal accommodations for performance. Secondly, in eight years of employment, this employee had only had two transcription errors until the recent pattern.

The recommendation from the consultant was for the employee to have an eye exam at the Nursing Home's expense. The eye exam revealed that the employee was in need of new glasses with the addition of bifocals. Upon interview, the employee shared that she had divorced a year ago and was having difficulty making ends meet. She had two children to support. She knew she needed new glasses but could not afford them. Her frustration and stress over the fear of losing her job was making her transcription errors worse in the past few weeks.

In a new corrective action plan, the Nursing Home paid for her glasses and payroll deducted the cost in small amounts over several months. With the new glasses, the errors went away, the employee went back to being a top performer and the Nursing Home retained a valuable employee.

Understanding the impact when increase performance demands meet decreased human performance potential

Case Study #2 SB was considered to be one of the best nurses at Sunnyville Hospital. She had worked her way up through the ranks from a nursing assistant to the medication nurse on a 30 bed medical surgical floor. The entire time she was in school, she worked fulltime at the hospital and had been an employee for 11 years. Patients loved her because she had a very pleasant and caring nature. Coworkers respected her for her dedication and her willingness to be a team player. SB had been named employee of the year on multiple occasions and was honored by a local association based on the recommendation of her coworkers.

Consistent with national trends, Sunnyville Hospital had been struggle with staffing shortages. Scheduling had become a nightmare during holidays and during peak vacation times. SB could always be counted on to do her share.

We live by encouragement, and we die without it– slowly, sadly and angrily. In our present systems, healthcare is dying a very slow and painful death. Our patients and communities will be the ultimate victims.

On the second Friday of a two week pay period where SB had worked eight extra shifts, her shining career fell apart. She was passing medications at the afternoon shift change. During shift change, she was the only nurse on the floor as all other outgoing and oncoming nurses were in report. The cardiopulmonary department was short three employees that day so she was also responsible for respiratory treatments. The unit had had an unusually high number of admissions that day so she had been asked to help with admission assessments. The unit also had received two transfers from ICU with a large number of IV medications. Throughout the day, SB had been periodically checking on her father who was on a different unit and had had surgery that day for cancer. She had asked for the day off to be with her mother and father but staffing did not allow for it. At 3:15 p.m., SB became distracted by a patient's family who were upset with their father's care. While attempting to meet everyone's needs, SB failed to double check the unit of blood that had just come up from the lab and hung the wrong blood. The patient had a severe hemolytic reaction and died.

SB was suspended pending investigation of the incident. Despite the fact that SB had one of the lowest medication error rates in the building and had never had a significant error in the past, she was placed on probationary monitoring when she returned to work and became the focus of a state professional conduct investigation. The stress of the event and the resulting situation forced SB to resign her position and seek out a different career path. The organization and healthcare industry lost a capable and dedicated professional. As a result of the focus on SB, the variables that came together to create the environment for this error were not addressed because the hospital and everyone involved focused only on the person with little attention to the context in which the error occurred.

There are too many variations of Case #1 and Case #2 scenarios occurring in healthcare facilities. While most are not as extreme as Case #2, they can be just as damaging. Our quality improvement activities must stop offering our workforce up for sacrifice. The assumption that all errors are the result of irresponsible, lazy and uncaring employees is dangerous for our workforce and true quality.

Quality improvement efforts will never achieve the positive outcomes they are intended to produce unless we refocus our efforts and take the pressure of our healthcare professionals. Corrective actions associated with quality improvement programs need to move away from being punitively oriented. Leadership needs to learn techniques of context evaluation and management. For employees who need additional skills and knowledge, we need to learn techniques of "redirecting." Redirecting involves addressing the error or problem as soon as possible, clearly and without blame. It is important that individuals understand the negative impact of the error without it being made personal. They need to understand how to achieve improved performance while still being comfortable that we continue to have confidence in them, and that we appreciate their contributions.

As Celeste Holm once said, "We live by encouragement, and we die without it– slowly, sadly and angrily." Organizations and quality improvement programs that don't promote success are doomed to fail.

Focusing of Outcomes So People Can See and Feel Success

Another facet of past performance improvement activities in healthcare is that they have been heavily process-oriented. Many organizations have a lot of activities going on but are not necessarily achieving an equal number of positive outcomes. This has fostered employee perceptions that quality improvement activities are simply something foisted on the workforce as a way to make them work harder.

In past years, there has been considerable debate over whether healthcare quality initiatives should be outcome or process focused. The fact is that both are critically important but they have distinctly different roles. Outcomes without process drivers do not communicate how the outcomes are to be achieved or the best way to get there. Process drivers without outcome measures may achieve what appear to be short-term operational improvements but frequently result in no long term success and create overly complex activities.

If we don't understand where we want to be, how will we know when we get there!

Defining the desired outcome creates the foundation for the goals necessary to guide people to achieve and feel success. All good performance starts with clear goals. Without outcomes and goals, people often head down the road of least resistance and success is rarely waiting there for them.

Case Study: Consider the hospital that has received a deficiency because admission nursing assessments are not completed in a timely fashion. The requirement is that admission assessments are completed within 12 hours of admission. Upon survey, 50% of all nursing assessments remained incomplete 72 hours after admission. The nursing department established a team charged with correcting the deficiency. After two meetings, the team decided that it needed to develop a new nursing assessment form. After twelve weeks of meeting every other week, the new form was rolled out. The new form was eleven pages long as compared to the previous form that was six pages in length and increased the time need to complete it from fifty minutes to ninety minutes. When the form was rolled out to the general staff, the committee members suddenly found themselves as outcasts in the workforce and the nursing management team acquired the label of incompetent fools.

In analysis of the situation, everyone agreed that there was nothing wrong with the original form and it was retained. Everyone agreed that the activity took on a life of its own and focused on an avenue that was easier. It was easier to create a new form than it was to address all the issues, both individual and organizational, that kept nursing assessments from getting done within 12 hours of admission. Without a clearly articulated desired outcome, the team found it easier to head down a road that got them in trouble with the staff, damaged the credibility of everyone involved and did not solve their problem.

Process-oriented activities also make it harder to measure and monitor for success. In writing desired outcomes that clearly articulate what is to be achieved, it is important to make them as detailed as possible. The details help to reduce the likelihood that those responsible for the change will stray and help people to feel a sense of accomplishment when they achieve the outcomes. Details make it easier to measure and communicate success. Consider which of the following outcomes best identify the desired outcome and would give staff a greater sense of accomplishment when it was achieved.

Too reduce medication errors

or

To reduce transcription errors from 53% to less than 5% of the overall medication errors in the next 12 months.

To reduce employee work related injuries

or

To reduce back-related work injuries by 80% in the next 12 month period.

To increase patient satisfaction in the emergency room

or

To increase patient satisfaction in the emergency room regarding timeliness of care.

or

To increase patient satisfaction in the emergency room wait times by having initial nursing assessments occur within 15 minutes of patient arrival in 90% of the cases.

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Darlene D. Bainbridge & Associates, Inc. is a consulting firm that specializes in issues affecting rural and smaller healthcare providers and communities. Mrs. Bainbridge holds certifications in both healthcare quality and healthcare risk management. She brings more than 20 years of experience in both areas to her consulting relationships. Coupling this with her experience in rural hospital, long term care, and network leadership, she has a perspective of healthcare that facilitates creating value-added solutions. "At Darlene D. Bainbridge & Associates, Inc., we are committed to helping our nation's healthcare organizations to find ways to meet the challenges of our rapidly changing healthcare environment and to make their success a reality."

"From Common Sense to Health Cents"
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Inside This Issue:

" Meeting Patient Requirements Through Quality"

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Recommended Reading Materials:

1. *The Balanced Score Card* by Robert S. Kaplan & David P. Norton, 1996.
2. *The Strategy Focused Organization* by Robert S. Kaplan & David P. Norton, 2001.
3. *Whale Done! The Power of Positive Relationships* by Ken Blanchard, Thad Lacinak, Chuck Tompkins, and Jim Ballard, 2002.
4. *The Extraordinary Leader; Turning Good Managers into Great Leaders* by John H. Zenger & Joseph Folkman, 2002.
5. *The Bad Attitude Survival Guide* by Harry E. Chambers, 1998.

Too often, people make the mistake of thinking that a process is the outcome. Implementing a new form, starting up a new program, disciplining an employee, or limiting a physician's privileges may represent an action but they do not necessarily lead to improvement. When a process or activity is treated as the outcome, the result is often a slower rate of decline rather than sustainable improvement. This is because process-oriented thinking without defined outcomes tends to treat any change as an improvement. The process fails to recognize that change does not automatically create improvement. Often, poorly orchestrated change simply complicates the issue being addressed.

Quality is about connecting with our patients and communities.

Improvements that are not tied to clearly articulated outcomes tend to be short-lived as they are difficult to measure for success and monitor for continued compliance. Too often, these activities are more difficult in soliciting staff buy-in and frequently involve a higher level of complexity that makes sustainability difficult.

Implementing a new employee injury management program does not have as great a potential for success as the goal of reducing employee injuries by 50% over 12 months. Implementing a new medication administration system is a process where related outcomes could be reducing medication errors by 50% over 6 months and reducing medication deliver time by one hour.

Far too many quality initiatives are a knee-jerk reaction to some outside pressure. Knee-jerk activities rarely achieve sustainable, long-term positive outcomes. They tend to result in a band-aid effect that simply holds the process together or hides the reality of it. After a while this band-aid approach moves from using one inch strip band-aids to using 4x4 sponges. If the approach continues nothing less than an ABD pad will work.

If the desired outcome is clearly understood, the potential to develop a strong process that will achieve that outcome is much more likely. It is easy to see how the context in which care is delivered can be more easily evaluated and managed to improve margins for quality and patient perception if the desired outcomes are clearly understood, articulated and fostered.