LESSON 24

Improve Quality and Safety

Nurses are patients' best hope—but we have yet to realize our full potential. Our knowledge, skills, and proximity to patients put us in the best position to ensure all patients receive high-quality, safe, and evidence-based care. The nursing process provides a useful framework for identifying and rectifying problems with care. The public has long trusted the nursing profession above all others; in their most vulnerable state, patients and families count on us to advocate on their behalf. Yet, research studies show we have unfinished business. As nurses, we have the opportunity and the obligation to learn and apply the latest techniques to optimize care and the patient experience.

—Christopher R. Friese, PhD, RN, AOCN, FAAN, professor, University of Michigan School of Nursing, Ann Arbor

Your most important job as a nurse leader is to ensure the safety of patients, employees, and visitors—essentially everyone who enters your organization's work environment. Immediate correction of threats to quality and safety comes before any other priority. Work on the organization's goals, vision, and long-term strategy cannot proceed until everyone is safe.

Today's nurse leaders must have a solid perspective on care delivery processes and evidence-based clinical guidelines to fully understand the route to the best, safest, and highest-quality care. They must comprehend how to improve, step by step, the quality

of care given to all patients and how to ensure that safety remains paramount in an organization's ethos. Because you will likely be held increasingly responsible not only for your hospital's financial outcomes but for its clinical ones as well, taking an active role in understanding processes and procedures is a solid first step toward asserting your commitment to the place and its people.

Consider the following points as you prepare for increasing responsibility as a leader:

- **Know what it means.** Knowing nursing vocabulary isn't enough. To become an expert, you also need to study quality and safety as a subject matter topic, reading case studies that describe which initiatives have worked well for organizations of various types and sizes, which attempts at improvement have failed, and why. Take time to understand the relevant terminology as you do your research. You should be able to read and understand the quality and safety indicators that are driven by the Centers for Medicare & Medicaid Services and various third-party contracts and agreements. If you are working in a hospital or other provider institution, there is likely a series of documents that explicitly state how quality and safety are practiced and measured. Find them and pore over them. The more you read, the more you'll know. Absorb everything you can in this area.
- **Develop a culture of improvement.** As you work to make things better, involve everyone—from the board of trustees on down. Tell them what you think needs work in the areas of quality and safety, and listen intently to what they believe are areas of strength and deficit in this regard. Be open and honest about your organization's shortcomings, and join your colleagues in seeking solutions. Ingrain the importance of specific, visible programs—for example, nurses might wear a fluorescent sash as a sign

of concentration as they measure outpatient medications so that others don't interrupt them—and, as new ideas take root, talk candidly about how a particular initiative is going. Express your continued reliance on your colleagues, and remind them repeatedly that an open, communicative culture is the best first step toward making thoughtful, prudent, lasting change.

- **Express quality and safety in financial terms.** In addition to being the right thing to do, doing something right the first time is always most cost-effective. Preventable errors can lead to everything from a poor organizational reputation for quality to fines, bad press, and lawsuits. Let your colleagues and employees understand the financial fallout from errors in a dollars-and-cents manner by giving them examples. For example, *Each of the _____ hospital-acquired infections at one local medical center cost it more than $_____ million. Unnecessary duplication of medical procedures cost the patient $_____ as well as untold wasted hours and stress.* Institutions follow their quality indicators closely because payments from federal, state, and various third-party sources are increasingly based on quality and safety. Quality and safety matter for myriad reasons—including the bottom line. Express it as such.
- **Look for sustainable, systematic solutions to problems.** Stop the immediate threat, of course, before changing the system so that the threat does not recur. Take care not to overcomplicate it—often the best solutions are simple, inexpensive, and easy to implement. Got a hand-washing compliance problem? Place signage outside and inside the room, along with sinks and soap. Encourage patients to ask nurses and physicians whether they've washed their hands. Institute other best practices for hand hygiene, and monitor compliance at random times.

- **Continually improve.** If patient falls appear to be on the rise on a particular unit, dig into the situation, determine the cause of the increase, and then improve the process to prevent future falls. Don't overlook simple solutions, though they may not always solve the entire problem. The solution may be as simple as changing the brand of floor wax or the floor-cleaning schedule. Or perhaps an increasing number of elderly patients are being treated in a particular wing of the hospital, or nursing staff have too high a patient load. Training in Lean and Six Sigma improvement methodologies may help solve safety and quality problems such as these.
- **Plan, practice, and measure.** A good plan is a key component of a successful safety program. Make yours as thoughtful and responsive to all facets of the problem as possible. As you develop your plan, make sure it's current with best practices and continually followed up and improved on. Pay close attention to details as you examine an issue before determining a course of action. After you create a plan, monitor the issue and watch for improvements.

  Thus, if your hospital has a growing problem with infections, it may stem from something as basic as poor hand washing or lackluster care of medical instruments. At the outset, you might ask what procedures and reminders are in place for hand-washing compliance and stethoscope cleaning. Then you might inquire about institutional benchmarks and look at the ways other organizations have solved similar issues to prevent infection. What are the hand-washing benchmarks? What changes can your organization make to improve your results? How will you measure whether you're moving the needle in a positive direction?
- **Report your results.** What gets measured gets improved. Insist on transparency, even if the issue is a sensitive one.

(*All* issues are likely sensitive, so you'd best be open about everything.) Share the shortcomings with your colleagues and employees—and impress on them the success that you hope procedural improvements will bring.

- **Develop the personal skills needed to improve safety and quality.** Ensure that both you yourself and the members of your team have the knowledge and skills needed to undertake improvements.
  - Familiarize yourself with the initiatives of the Institute for Healthcare Improvement (IHI).
  - Learn about Lean or Six Sigma improvement techniques.
  - Enhance your financial understanding of value-based purchasing and its connection to quality outcomes and patient satisfaction.
  - Support and work with interprofessional teams to identify opportunities for improvement.
  - Support regular training programs for all staff. Quality and safety depend on the best available evidence and successful practices. Continuing education programs—such as workshops, lectures, retreats, and professional development days—are essential for everyone.
- **Link quality and safety to evidence-based practice.** Not only must care be safe and of high quality, but it also must be the *right* care, proven through scientific evidence to produce the best outcomes.

Above all, develop a passion for improving quality and promoting safety throughout your career as a nurse leader. It is, after all, the most basic, fundamental way to help.

EXERCISE 1

Identify a process in your organization that needs improving, taking notes on what you observe. Is the intensive care unit rife with dissonant, impossible-to-locate patient alarms that fatigue the ears of staff and patients? Are patients not sleeping in the labor and delivery unit because of doors slamming and elevators chirping? Is the emergency room waiting area backlogged for hours with sick people? Are reception staff overwhelmed and terse? Jot down a list of red flags and try to identify some possible solutions.

EXERCISE 2

Earn an IHI Open School Basic Certificate in Quality and Safety.

RESOURCES

Institute for Healthcare Improvement (IHI). 2016. "Open School." Accessed July 18. www.ihi.org/education/ihiopenschool/Pages/default.aspx.

White, K. R., and J. R. Griffith. 2016. *The Well-Managed Healthcare Organization,* eighth edition. Chicago: Health Administration Press.