Empowering Nurse Leaders through Innovations in Person and Family Centered Care

Erica Reid, IHI/Health Foundation Quality Improvement Fellow

Session Objectives

- Describe high impact actions and strategies that can lead to excellent patient experience
- Discuss ways in which patients participate in health care and how to use their experience effectively
- Contribute to generating ideas on improving patient experience across the continuum of care
- Consider how a ‘clues framework’ can guide excellent patient experience

@nurses_qi
Session Overview

Structures to support excellent patient experience  
*Cheryl Hoying*

Patient and family advisory councils  
*Rick Evans and Susanne Goldstein*

Coffee 10.45 – 11.15

The snorkel…  
*Annette Bartley*

Patients are detectives  
*Len Berry*
Structures to Support Excellent Patient Experience

Cheryl Hoying PhD, RN, NEA-BC, FACHE, FAAN
Senior Vice President, Patient Services
Cincinnati Children’s

This presenter has nothing to disclose.

Presentation Objectives

Attendees will learn:

• How Cincinnati Children’s structure strives for an excellent patient experience

• How Cincinnati Children’s practice model has the patient as part of the care team
There is solid evidence that leadership engagement and focus drives improvements in health care quality and reduces patient harm. Leaders at all levels in care delivery organizations are struggling with how to focus their leadership efforts and achieve Triple Aim results for the populations they serve. High-impact leadership requires leaders to adopt four new mental models:

1. Individuals and families are partners in their care
2. Compete on value, with continuous reduction in operating costs;
3. Reorganize services to align with new payment systems
4. Everyone is an “improver”

Institute for Healthcare Improvement
White Paper, 2013

<table>
<thead>
<tr>
<th>CULTURE</th>
<th>STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Encompasses values and behaviors consistently across the organization.</td>
<td>• A plan to get from Point A to Point B.</td>
</tr>
<tr>
<td>• Includes subcultures within the organization.</td>
<td>• Overcoming uncertainty and resistance to achieve aspirations</td>
</tr>
<tr>
<td>• Resistance to change is common.</td>
<td>• It defines what is important for the organization to do.</td>
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Dan Beckham, strategic consultant, H&HN Daily
Cincinnati Children’s Core Values

Respect everyone
• Treat others as they would like to be treated.
• When relating to patients, family members and colleagues, greet everyone warmly and sincerely; listen without interrupting.

Tell the truth
• Be honest and transparent in all interactions
• When relating to patients, family members and colleagues, communicate what is happening, admit mistakes, take ownership.

Work as a team
• Inspire, challenge and support colleagues, patients and families to advance the mission.
• When relating to patients, family members, and colleagues, work as a team.

Make a difference
• Go above and beyond in the service of others and Cincinnati Children’s.

A Cultural Shift is Taking Place

Patient Safety & Experience, Clinical Outcomes
→
Patient Safety Experience, Outcomes; Employee Experience, Outcomes

Value Social & Cultural Difference
→
Value All Differences – professional, teamwork, respect

Care giving, Nice
→
Accountability, Responsibility

Decision-making; Hierarchical, Individual, Consensus
→
Effective Decision-making structure & Change Mgmt
MACRO SYSTEM
Board of Trustees

MESO SYSTEM
• Patient Services Division,
• Operational Excellence
• Interprofessional Practice Model

MICRO SYSTEM
Health care team impact

Board of Trustees – Patient Care Committee

• Provides strategic input and oversight with respect to patient care goals and activities.

• Receives reports on safety and quality improvement.

• Educates and advises the larger Board on patient care issues related to:
  a) Safety/safety culture
  b) External and regulatory agency surveys and compliance
  c) Care coordination and outcomes of chronic and complex diseases
  d) Flow
  e) Patient experience
1. Every monthly meeting begins with a safety report

2. Every presentation begins with a patient story

3. If a Serious Safety Event in their clinical area occurred, the presenter reports on follow-up and future preventive measures

4. Every meeting includes reports on quality

5. Presentations are by physicians/staff (NOT senior administrators)

6. Senior leaders work with committee chair to set the agenda

Sample agenda items:
- Infection control
- Chronic Care
- Population Health
- Psychiatry
- Transplant
- Emergency
- Care Management

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Board of Trustees

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- Operational Excellence
- Interprofessional Practice Model

MICRO SYSTEM
Health care team impact
Psychiatry Services Quality & Safety

- Psychiatry Assistant Vice President has a physician counterpart for overall psychiatric care
- Physician and nurse leader at each location

A model for team unit-based leadership

- Adhere to Standards
- Improve processes and practices
- Drive accountability for results

- Strike the right balance between standardization & innovation
- Establish a team & collaborative environment that is enriched & led by Co-Directors (and their supervisors) working as partners to achieve unit & CCHMC results
- Increase the meaningfulness of the employee experience and the ability of every employee to make a difference
- Effectively manage flow, quality, safety and patient and family experience

- Planning & Prioritizing work
- Effective decision making
- Managing change
- Increasing accountability and ownership of results
- Improving the employee experience and ability to Make a Difference

College Hill
Inpatient Beds = 64
Residential Beds = 33

Lindner Center of Hope
Inpatient Beds = 16
Partial Hospitalization Beds = 16

Cincinnati Children’s Hospital
Inpatient Beds = 12

Green Township
Partial Hospitalization Beds = 16

College Hill
Inpatient Beds = 64
Residential Beds = 33

Lindner Center of Hope
Inpatient Beds = 16
Partial Hospitalization Beds = 16

Cincinnati Children’s Hospital
Inpatient Beds = 12

Green Township
Partial Hospitalization Beds = 16
Optimizing Outcomes, Experience & Value

- Develop Empowered & Accountable Microsystem Leadership
- Maintain Resilient Staffing
- Build Engaged & Committed Teams
- Reliably Implement Situation Awareness
- Reliably Execute Key Processes
- GARDIANS Daily Risk Management
- Partnering with Patients & Families

Every Patient

Integrated Care Delivery

Every Time

Patient Experience

Employee Experience

History of Shared Governance at Cincinnati Children’s


- The PCGC immediate past chair begins attending Patient Care Committee of the Board of Trustees.
- IMC Chair attends PSL monthly.
- PCGC and NPCC chairs join the Safety Operations Committee.
- PCGC begins development of the Interprofessional Practice Model.
- NPCC Chair & Chair-Elect join Inpatient CSI Leadership Team Meetings.
- Inpatient Nursing Cluster representatives join Serious Harm Collaborative in January.
- Chairs of NPCC and PCGC follow in July 2013.
- PCGC launches Interprofessional Practice Model

GARDIANS: Global Automated Risk Detection Interface and Network System

Nursing Shared Governance (SG) structure was implemented.
An Allied Health SG Structure was created.
Merging of two independent structures.
Launch of new Interprofessional SG Structure.
NPCC Immediate Past Chair attends the Patient Care Committee of the Board of Trustees.

PCGC chair starts attending PSL monthly.
PCGC chair starts attending Medical Executive Committee meeting monthly.
SG champions integration of IPM into clinical decision making and evaluation of practice in annual performance review.
Gears of the Interprofessional Practice Model

SAFETY
Protective practice that results in the elimination of all preventable harm to our patients, families, visitors and staff.

COMPREHENSIVE COORDINATED CARE
The assessment, interventions, skills, therapies, care and coordination of a plan of care that includes the medical, social, developmental, behavioral, emotional, spiritual, educational and financial needs of those served.

INNOVATION & RESEARCH
The generation of new discoveries, creative use of technology, and transformation of evidence based knowledge and learning into practice and policy.

BEST PRACTICE
The integration of evidence, expertise, and patient/family expectations to better serve patients and families.

PROFESSIONALISM
The continuous growth of knowledge and experience through education, practice, and research. Maintain and uphold standards of practices, ethics, cultural competence & core values; foster a team based approach to patient care.

COLLABORATIVE RELATIONSHIPS
Active participation among health care team members, patients and families, and community; empowers all members to share their expertise and ideas with respect of everyone’s strengths & diversity.

Interprofessional Practice Model

Our Core Values:
- Respect Everyone
- Tell the Truth
- Work as a Team
- Make a Difference

Examples of optimal outcomes:
- Supporting end of life
- Functional capacity
- Reducing disability

The PATIENT is part of the team
### Optimal Outcome:
**SPREAD OF AGGRESSION MANAGEMENT BUNDLE**

<table>
<thead>
<tr>
<th>Safety</th>
<th>Comprehensive Coordinated Care</th>
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<tbody>
<tr>
<td>Psychiatric Aggression Prevention Standards.</td>
<td>Intake through post discharge standardization of aggression assessments and management</td>
</tr>
<tr>
<td>Process Measures for each process of the “bundle”</td>
<td>Coordination model across multiple systems</td>
</tr>
<tr>
<td>Outcome measures = Seclusion/Restraint reduction, Patient Self-Harm Levels 6 thru 9, Employee Injury</td>
<td></td>
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<tr>
<th>Innovation &amp; Research</th>
<th>Best Practice</th>
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<tbody>
<tr>
<td>Brief Rating of Aggression by Children and Adolescents &amp; Overt Aggression Scale</td>
<td>Therapeutic Crisis Intervention – Model for prevention, de-escalation, intervention and de-briefing crisis</td>
</tr>
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<tr>
<th>Professionalism</th>
<th>Collaborative Relationships</th>
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<tr>
<td>Weekly Situational Awareness Oversight Team and Weekly Quality “huddles” by leaders.</td>
<td>Juvenile Court System, Court Administrator, Superintendent of the Youth Center</td>
</tr>
<tr>
<td>Alignment of Crisis Intervention instructors with role modeling, coaching, 5:1 feedback</td>
<td>Cincinnati Police Department Captains – Handoff Procedures</td>
</tr>
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### IMPLEMENTATION

- Add to new employee orientation.
- Dedicated webpage on intranet.
- Interactive web-based education (posted on our webpage).
- Large banners with model displayed on walls at every point of care.
- Badge cards distributed.
- Share “Get in Gear” story at meetings to indicate IPM effectiveness

Add this job responsibility to clinician’s performance review:

*Demonstrates consistent integration of the IPM in all aspects of practice.*
MACRO SYSTEM
Board of Trustees

MESO SYSTEM
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MICRO SYSTEM
Health care team impact

PERIOP SAFETY

Three Daily Huddles

6:45am
ATTENDS: Charge Nurse for SDA, OR and PACU; Anesthesiologist; Periop coordinators; SPD manager; VAT, MRI

Review the status of every patient; change their risk level if appropriate.

2:15pm
ATTENDS: Charge Nurse for SDA, OR and PACU; Anesthesiologist; Periop coordinators; SPD manager; VAT, MRI

The Charge Nurse runs the huddle. Every patient’s risk level is determined, based on health condition, procedure or both. Patients arriving the next day are reviewed.

9pm
ATTENDS: OR and PACU Charge Nurse; Anesthesia board runner.

Patient status is reviewed with input from staff and our periop coordinators who have been updated by surgeon and anesthesia.
PATIENT STATUS IS DEFINED AS:

**Green** = all clear, patient prepared and verified “no threats to patient safety” through the perioperative area.

**Yellow** = Keep close watch – elevated risk factors for patient safety identified. Proceed with caution. Communicate additional needs to Charge Nurse.

**Orange** = “High Alert” risk for patient vulnerability during the perioperative process. Requires additional resources and/or support from perioperative expert.

**Red** = the highest indicator which requires stopping the line until the perioperative safety communication system has resolved the identified threat.

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**Example of Huddle Outcome**

1. Patient identified as being obese.

2. Extra large stretcher (bariatric patients) is ordered for moving patient. Ensures comfort and safety.

3. Extra large bed with side rails is ordered.

4. Patient assigned room with hydraulic lift to ensure nurse’s safety in moving patient.
Connecting with School Nurses

To help detect children with poorly controlled asthma.

* Program was piloted in eight schools. Now being expanded to entire Cincinnati district of 55 schools.

1. Provide more training for school nurses about asthma

2. Provide school nurses limited access to electronic medical records (student’s asthma action plan, medications)

3. Phone huddles with 1) school nurse, 2) Cincinnati Children’s asthma care coordinator, 3) pulmonary nurse

4. School and play for children = work for adults

“The vast majority of kids with poorly controlled asthma do not come to the hospital. Instead they are coughing every night, not participating in sports, and enduring other limitations on their lives.” Maria Britto MD
VIDEO DISCHARGE

Discharge instructions on Video

• After hospitalization, kids help create their own personalized video about how to care for their asthma.

• The video includes:
  • Segment of child using meds properly
  • Instructions from nurse/therapist
  • List of asthma triggers, meds, dosage

• Follow-up comments from kids:
  • “I like watching myself in my video.”
  • Many kids report that they insist their parents, siblings and other caregivers watch the video so they know how to properly care for asthmatics.

COLLABORATION

COLLABORATING WITH NEIGHBORHOOD PHARMACIES

PROBLEM:
Asthmatic children from low socioeconomic and inner-city backgrounds have poor medication adherence. (i.e. inhaler not available in home when needed)

WHY POOR ADHERENCE:
• Logistical reasons
• Financial reasons
• Hassle
SOLUTION:
Partnership with pharmacies that offer automated refills and home delivery.

Original enrollment: 25 children received automatic inhaler refill each month, delivered by pharmacy. At enrollment their average refill rate was 20%

16 months later: Average refill rate 98%

ROLL OUT:
Program has spread to surrounding counties in southwest Ohio. Enrollment now at 130 children.

RESULT:
Asthma morbidity has significantly decreased.

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GAUGING STRESS

Fishbowls in the NICU -
gauging parent and staff stress during construction
Parents

- I felt very supported by NICU staff today
- I felt somewhat supported by NICU staff today
- Red I felt I needed more support from NICU staff today

Staff Reps

- No stress today
- Little stress today
- Increased stress today
- Very stressful today

GAUGING STRESS

HOME VISITS
Building skills to help children recover and stay well

Infusion Pharmacy
24,125 Prescriptions

Liaison Resources
2,984 Pre-Discharge Teachings

Rehab Equipment
2,2082 patients; 202 custom wheelchairs

StarShine Hospice
3,016 Hospice & Palliative Care Visits

Private Duty Nursing
91,225 Hours of Care

Home Health Agency
14,854 Nursing & Ancillary Visits

Home Care Services

HME & Respiratory
14,785 Deliveries

10/28
215p
615p
215p
615p
215p
615p

Comments

HOME CARE

19
Home Visit Program
to recently discharged patients

- Visited Cuba 2011.
- Pilot program initiated in 2012
- Visits conducted within 48 hours of discharge from a general medical-surgical unit
- Ease the transition from hospital to home
- Help prevent a hospital stay or trip to the Emergency Room
- No charge to parent or insurance

Patient/Family Benefits

- Receive information and resources to care for the child
- Learn skills to feel comfortable and confident in supporting recovery
- Ease the transition from hospital to home
- Future idea: Kids learning to do PDSAs
- Intervention for non-compliance with medication regimen
Primary grant objectives:
Demonstrate the value of a nurse home visit to reduce unplanned health system utilization.

- $1.5M grant awarded.
- Study transitions from hospital to home for acute care pediatric patients.
- We are in the first year of the three year randomized control study.
- Participant involvement in the study will be 18 months.

FIRST FIVE MINUTES
- Review the goal of the visit.
- Develop a personal connection.
- Is there anything else you’d like to discuss?

LAST FIVE MINUTES
- Uncover any unresolved issues.
- Let parent know who to contact.
- Confirm next appointment.

*Is it apparent to the parent??*
Home Care Escort Program

• Enables Home Care Services to every patient in any home/community.
• Ensures staff safety.

1. Patient’s address is analyzed for violet crime within .2 miles

2. Results determine if escort is required
   1. Escort after 1pm
   2. Escort at all times
   3. Escort needed. No visit after 5pm
   4. Escort needed. No visit after 1pm
   5. Deputy escort is required.

3. Escort drives and accompanies staff into the home.

4. Escorts are trained in community surveillance and de-escalation techniques.

• Healthcare is complicated. There are numerous healthcare providers involved.

• Let’s look at it from a patient’s perspective.

• Meet Gabe!
Gabe’s Chronic Care Map

Care Management Structure

PATIENT IS FOLLOWED ALONG CONTINUUM OF CARE
Instead of care managers being divisionally based, they now follow patients across the continuum of care. Prior to this change, parents didn’t know who to call.

STANDARDIZED PRE-VISIT PLANNING
The goal is to have each patient screened, assessed, and risk-stratified.

STANDARDIZED SELF MANAGEMENT SUPPORT
Enables patients and families to take more responsibility for their care instead of leaving it all up to the clinician.
New structure has enabled rotation of nursing staff between inpatient and outpatient settings. Work 50% inpatient, 50% outpatient.

PILOT: Focused ethnography to enhance job role satisfaction through a unique inpatient/outpatient role. We will monitor the attitudes, knowledge and beliefs of the RNs as they experience a new role.

PRIOR EXPERIENCE HAS SHOWN:
- Better discharge planning/Improved continuity of care
- Averts burnout
- Increased job satisfaction
ALLIED HEALTH integration with care team

• Increasing inpatient and outpatient continuum of care.

• Clinical pharmacists now a part of medical teams:
  1. Lung transplant (10 patients)
  2. Liver transplant (40 patients)
  3. Cystic Fibrosis (30 patients)

• 4 Respiratory Care Team Members for CF/Airway Clearance, Severe Asthma and Lung Transplant patients.

• 3 Child Life staff for Adaptive Care Team (developmental and behavioral) patients during inpatient stays and outpatient visits.

• Audiologists for hearing aid and Cochlear Implant patients.

UNLEARNING

Sometimes unlearning is necessary to get to Quality and Safety.

UNLEARNING is letting go of old knowledge or old ways of doing business. This is an incredibly hard thing to do, but it is a skill that all of us will need to practice with increasing frequency.

UNLEARNING prepares us for a better way of doing something.

Jack Uldrich
UNLEARNING EXAMPLE: Safe Sleep of infants on back vs. stomach.

UNLEARNING EXAMPLE: We don’t like our children to play too many video games. But surgical residents performed better during simulated surgery after playing on a Wii console. It improved dexterity for laparoscopic and microscopic work.

Every mile you go in the wrong direction is really a two mile error. Unlearning is twice as hard as learning.

Unknown
LEADERS

CULTURE

STRATEGY

• Culture eats Strategy for Breakfast/Lunch

• Is it too big to eat for dinner?

• Culture is well-positioned to eat Strategy but only when leaders don’t execute.

• Then Culture eats weak leaders; we can’t be in the forefront of Quality and Safety.

Dan Beckham, strategic consultant, H&HN Daily
Session Objectives

- Understand common structures and function of PFACs
- Identify best practices for engaging patients and families
- Understand optimal methods for engaging patients from the standpoint of a patient advisor
- Identify barriers to effective patient engagement and ways to overcome those barriers
An Opening Poll – You and Your PFAC

› Does your organization have a PFAC?

› In your opinion, how effective is your PFAC in advancing patient and family centered care?

› What are the major barriers to making your PFAC even more influential and effective?

Massachusetts General Hospital

› 1000+ Beds
› 47,000 Discharges
› 1.4 Million Outpatient Visits
› 88,000 ED Visits
› Harvard Affiliated
› Largest hospital research budget in the US – $764 Million
What are Patient and Family Advisory Councils (PFACs)?

- Collaboration between patients, families and the hospital
- Populated by patients and family members
- Supported and facilitated by hospital administration
- Advisory to hospital leadership
- Interface with many areas of the hospital
- Advance patient and family centeredness

MGH’s Patient and Family Advisory Councils (PFACs)

- MGH Hospital for Children PFAC (1999)
- MGH Cancer Center PFAC (2001)
- MGH Institute for Heart, Vascular and Stroke Care PFAC (2007)
- The General Hospital PFAC (2011)
- Pediatric Oncology PFAC (2014)
Patient Advisors – Programs and Venues

- Family faculty
- Key committee members
- Patient and family panels
- Special projects
  - Patient portal, EHR conversion
- Formal Structures:
  - Terms, job descriptions, orientations

PFACs and Hospital/Healthcare Priorities

- Patient and family experience
- PCORI projects
- Population health management
- Patient Centered Medical Home
- Shared decision making
- Diversity/special populations
- Overall quality improvement
- ACO implementation
- Strategic Planning
Engaging Members – An Advisor’s Perspective

Learnings for Members

› Understand why you are volunteering. Tap into that motivation and you will love serving
› Hospitals move at a different pace – you have to have patience
› Collaboration is the only way through the frustration

Engaging Members – An Advisor’s Perspective

Learnings for Hospital/Staff

› An engaged membership can make all the difference at the hospital
› Essential to tap into what motivates members
› Different types of voices matter. Talkers v. non-talkers. Learn how to incorporate differing contribution styles
› Build relationships – we're still learning
Engaging Members – An Advisor’s Perspective

Learnings for Hospital/Staff
- Find a patient to be part of leadership
- Recruiting—be intentional.
- Understand the council culture, match the people to the work needed
- Find alternative placement for good people/bad match
- Plan the onboarding process to ensure alignment

Discussion – Overcoming Your Barriers
- Table discussions
  - Review barriers
  - Brainstorm and share ideas
- Group sharing
The Snorkel-
A process for generating ideas for improving care and care experiences from the frontline

Annette Bartley RN BA BS MPH
Quality Improvement Fellow (Alumni)
December, 2014
The Snorkel

- Taps into existing creativity
- Liberates thinking
- Generates energy and enthusiasm
- Engages staff
- Helps move individuals past learned helplessness
- Focuses minds on the positive
- Supports action

To Innovate is to Thrive

*The key to unlocking innovation is to apply both types of thinking with equal authority and in the right order.*
IDEO – “The Deep Dive”

*™

• IDEO is one of America’s Leading Design Firms
• IDEO’s special ingredients:
  – Teams
  – Culture
  – Methodology

Outline of “Snorkel”

- Review of Project Vision and Charter
- What do we know about the current context?
- Propose a Design Challenge
- Storytelling
- How might we....?
- Brainstorming
- Select top ideas (multi-vote)
- Prioritize ideas for development
- Plan prototypes
- Enactments
- Design first series of tests
Understand the current context

❖ What has worked well?
❖ What has been challenging?
❖ What needs to improve?

Storytelling

• In lieu of doing actual observations, use storytelling to “observe” actual experiences
• Recall an actual story or experience which relates to the specific design challenge (personal, friend or family member or work-related experience)

  ✓ Who was involved?
  ✓ What happened?
  ✓ How did individuals feel and react?

• Give an example
• Tell stories in small groups (nor more than 2 minutes each)
Design Challenge

How might we engage patients and families to play a more active role in their own care?

Rules for Brainstorming

*Chose one or two “how might we scenarios….*

- encourage **wild** ideas
- go for quantity – want more than 500 ideas
- defer judgment
- be visual – draw pictures
- one conversation at a time
- build on ideas of others
- stay focused on topic (“how might we...” scenarios)

*Write each idea on post-it notes*
Multi-voting /Select Top Ideas

- Cluster together similar ideas from the brainstorming exercise.
- Use dots to vote (everyone gets 7 dots):
  - What are your personal favorites?
  - What idea would you most like to try on your unit?
  - What idea do you think will have the biggest impact toward achieving the “how might we…”
- Participants can distribute their dots however they want — all on one idea, each dot on a separate idea, or anything in between.
- Report out on favorite ideas (where there are most dots).

Matrix of Change Ideas

<table>
<thead>
<tr>
<th>Easy to Implement</th>
<th>Difficult to Implement</th>
</tr>
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<tbody>
<tr>
<td>Low Cost</td>
<td>High Cost</td>
</tr>
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</table>

Place concepts in matrix. Strive for easy, low-cost solutions. Translate high-cost solutions into low-cost alternatives.
Matrix of Change Ideas

- **Low Impact**
  - Translate high-cost solutions into low-cost alternatives.

- **High Impact**
  - Strive for high-impact, low-cost solutions.

- **Low Cost**

- **High Cost**

Enactments

- Creating an enactment will help you illustrate an extreme future vision for your prototype
- Enables you to refine your thinking and build on ideas
- Helps to make your concept/abstract idea into something more concrete
Adaptations

- The Paddle
- The Moan Board
  - Adapt
  - Adopt
  - Abandon

Video clip

- This Team from Leamington in the UK wanted to engage patients and family members in helping to reduce their risk of developing pressure ulcers.
- They developed a simple video in collaboration with patients to get some simple messages out to people about things they need to pay attention to in order to reduce risk.
- It brought the teams and all involved in making it a lot of fun and it has had a significant impact across many organisations, helping to change the attitudes of staff regarding collaborating with patients and families to prevent harm.
Commitment to act

Model for Improvement

What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?

Changes That Result in Improvement

Very Small Scale Test

Follow-up Tests

Wide-Scale Tests of Change

Implementation of Change

Action

- What three key messages will you take away from to-day’s workshop?

- What three PDSA’s /changes will you commit to testing by next Tuesday
Engaging Heart & Minds

‘If you want to build a ship do not gather men together and assign tasks. Instead teach them the longing for the wide endless sea’

(Saint Exupery, Little Prince)

Questions?

abartleyconsulting@gmail.com
Patients are Detectives

Leonard Berry, PhD
Senior Fellow, IHI
Regents Professor
Mays Business School
Texas A&M University

Patients always have an experience when they interact with an organization

They consciously and unconsciously filter a barrage of clues and organize them into a set of impressions – some rational, some emotional
Each clue carries a message; the absence of clues also carries a message

The composite of clues creates the total experience

The more important, variable, complex, and personal the service, the more clue-sensitive people are likely to be.
Functional Clues

Clues emitted by the functionality of the good or service

Mechanic Clues

Clues emitted by stimuli associated with things – sights, smells, sounds, textures
**Humanic Clues**

Clues emitted by stimuli associated with people – choice of words, tone of voice, level of enthusiasm, appearance, body language

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**Clue Influences on Customer Perceptions of the Experience**

- **Clue Categories**
  - Functional
  - Mechanic
  - Humanic

- **Customer Perceptions**
  - Rational Perceptions
  - Emotional Perceptions
Humanic Clues

Exceeding Patients’ Expectations

Exceeding patient expectations requires the element of pleasant surprise

Human interaction between service provider and patient offers the best opportunity for pleasant surprise
## Ideal Physician Behaviors

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<th>Behavior</th>
<th>Definition</th>
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<td>Confident</td>
<td>The doctor’s assured manner engenders trust. The doctor’s confidence gives me confidence.</td>
</tr>
<tr>
<td>Empathetic</td>
<td>The doctor tries to understand what I am feeling and experiencing, physically and emotionally, and communicates that understanding to me.</td>
</tr>
<tr>
<td>Humane</td>
<td>The doctor is caring, compassionate, and kind.</td>
</tr>
<tr>
<td>Personal</td>
<td>The doctor is interested in me more than just as a patient, interacts with me, and remembers me as an individual.</td>
</tr>
<tr>
<td>Forthright</td>
<td>The doctor tells me what I need to know in plain language and in a forthright manner.</td>
</tr>
<tr>
<td>Respectful</td>
<td>The doctor takes my input seriously and works with me.</td>
</tr>
<tr>
<td>Thorough</td>
<td>The doctor is conscientious and persistent.</td>
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## Ideal Nurse Behaviors

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Humanic Clues in Nursing
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