Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

#PSAW18 - United for Patient Safety

The United in Patient Safety campaign culminates each year with Patient Safety Awareness Week (March 11-17,2018), designed to mark a dedicated time and a platform to increase awareness about patient safety among health professionals and the public. The theme for 2018 is "United for Patient Safety." This month, in recognition of #PSAW18, you'll find practical resources nursing homes can use to implement changes to improve patient safety culture and patient safety. This resource list is not exhaustive, but is provided to give initial guidance to nursing homes looking for information about patient safety initiatives.

Also, I've been studying leadership and vision for a culture of safety and what, exactly, is involved in building culture, and specifically, a culture of safety? How do health care leaders, experienced or not, acquire this skill and apply it? Given the relative lack of specific guidelines for leaders around safety culture, the American College of Healthcare Executives and the National Patient Safety Foundation (which has since merged with the Institute for Healthcare Improvement) recently convened expert panels to address these questions. The 2017 report from that panel, *Leading a Culture of Safety: A Blueprint for Success*, is designed to be used as a practical, tactical guide for leaders at any stage in their organization's culture transformation. I'd recommend it. The report suggests that leaders seeking to transform their organization's culture would do well to commit focused attention on six key areas:

- establishing a compelling vision for safety;
- building trust, respect, and inclusion;
- educating and engaging board members in patient and workforce safety issues;
- emphasizing safety in the development and recruitment of clinical leaders and executives;
- adopting just culture principles to focus on systems flaws over individual blame when things go wrong; and,
- setting and modeling behaviors such as transparency, active communication, and civility as expectations for all.

Leading a Culture of Safety: A Blueprint for Success provides a set of strategies and tactics for leaders to use to begin the process of culture transformation as well as a set to help sustain progress. Different organizations will be at different starting points, and some may already excel in one domain and seek to improve quickly in another. Underlying all of the work is a commitment to learning; continuous improvement; measurement, analysis, and interpretation of safety data; change implementation; and honest and open feedback.

Here are some resources organized by the composites assessed in the AHRQ's Nursing Home Survey on Patient Safety Culture. For the complete updated list, visit the AHRQ.

Composite 1. Overall Perceptions of Resident Safety

1. Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices
http://www.ahrq.gov/research/findings/evidence-based reports/ptsafetyuptp.html
This evidence report is featured on the AHRQ Health Care Innovations Exchange Web site. It presents practices relevant to improving patient safety, focusing on hospital care, nursing homes, ambulatory care, and patient self-management. It defines patient safety practices, provides a critical appraisal of the evidence, rates the practices, and identifies opportunities for future research.

2. Patient Safety Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/ PatientSafetySelfAssessmentTool.aspx

This organizational self-assessment tool was designed by Steven Meisel, PharmD, at Fairview Health Services using information from a report published by the AHRQ. The tool can help staff members evaluate whether known safety practices are in place in their organizations and to find areas for improvement.

Composite 2. Feedback and Communication About Incidents
1. **Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems**
http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf

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The National Association for Healthcare Quality Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems provides best practices to enhance quality, improve ongoing safety reporting, and protect staff. It addresses accountability, protection of those who report quality and safety concerns, and accurate reporting and response.

2. University of Michigan Health System Patient Safety Toolkit: Disclosure Chapter
http://www.ihi.org/resources/Pages/Tools/UMichiganHealthSystemPatientSafetyToolkitDisclosureChapter.aspx

The Patient Safety Toolkit was developed by University of Michigan with the financial support of Blue Cross Blue Shield of Michigan Foundation. The toolkit was designed to build a foundation of knowledge and to suggest practical applications for developing best practices. A chapter is dedicated to the disclosure of medical errors or unanticipated outcomes.

Composite 3. Supervisor Expectations and Actions Promoting Resident Safety and Composite 4. Management Support for Resident Safety

1. Appoint a Safety Champion for Every Unit
http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx

Having a designated safety champion in every department and patient care unit demonstrates the organization's commitment to safety and may make other staff members feel more comfortable about sharing information and asking questions. This IHI Improvement Web site identifies tips for appointing a safety champion.

2 .Partnership To Improve Dementia Care in Nursing Homes: State Coalition Provider Question Worksheet
https://www.nhqualitycampaign.org/files/Partnership_Provider_Assessment_Form.pdf

This provider self-assessment contains a list of questions for direct caregivers and nursing home leadership to assist facilities in assessing their approach to dementia care.

Composite 5. Organizational Learning

1. Patient- and Family-Centered Care Organizational Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx

This self-assessment tool was developed by the Institute for Healthcare Improvement (in collaboration with the National Initiative for Children's Healthcare Quality and the Institute for Patient- and Family- Centered Care). It allows organizations to understand the range and breadth of elements of patient- and family-centered care and to assess where they are against the leading edge of practice. Use this self-assessment tool to assess how your organization is performing in relation to specific components of patient- and family-centered care, or as a basis for conversations about patient-centeredness in the organization.

2. Quality Improvement Fundamentals Toolkit
http://www.ofmq.com/sites/default/files/QI_Fundamentals_508.pdf

This toolkit was developed by the Oklahoma Foundation for Medical Quality and can be used to help identify opportunities for improvement and develop improvement processes.

Composite 6. Training and Skills

1**. AHRQ Patient Safety Education and Training Catalog**
http://psnet.ahrq.gov/pset/index.aspx

The AHRQ's Patient Safety Education and Training Catalog consist of patient safety programs currently available in the United States. The catalog, which is featured on AHRQ's Patient Safety Network, offers an easily navigable database of patient safety education and training programs consisting of a robust collection of information each tagged for easy searching and browsing. The new database identifies a number of characteristics of the programs, including clinical areas, program and learning objectives, evaluation measures, and cost.

2. Applying High Reliability Principles to Infection Prevention and Control in Long TermCare
http://www.jointcommission.org/hripcltc.aspx

The goal of this educational module is to introduce persons working in nursing homes and assisted living facilities to the principles of high reliability and how they can be applied to preventing infections in residents. This 50-minute e-learning tool was developed by the Joint Commission with partial funding from AHRQ. It features quizzes and a searchable database of practical resources. The free CDs and online format are available to all facilities, not only Joint Commission customers.

3. Improving Patient Safety in Long-Term Care Facilities: Training Modules
http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/index.html

This training module is featured on the AHRQ Health Care Innovations Exchange Web site. The Improving Patient Safety in Long-Term Care Facilities: Training Modules materials are intended for use in training frontline personnel in nursing homes and other long-term care facilities. The materials were developed for the Agency for Healthcare Research and Quality (AHRQ) under a contract to the RAND Corporation.
They are organized into three modules:
Module 1: Detecting Change in a Resident's Condition
Module 2: Communicating Change in a Resident's Condition
Module 3: Falls Prevention and Management

Composite 7. Compliance With Procedures

1. Long-Term Care Toolkit

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Getting on the Same Page by Paige Hector, LMSW

Every Facility Has a Culture, What's Yours Like?

I love to read. Just when my husband and I donate a load of books, somehow Amazon seems to send more to fill the shelves. (I plead the 5th.) I just finished a great book called *The Year Without Pants* by Scott Berkun. It's the story of his experience leading a team at a company called Automattic, Inc. which runs the popular website WordPress.com (think blogs). His writing style is engaging and hilarious, the laugh-out-loud kind of funny that makes learning fun. In this book he tackles topics from leadership to productivity and work in general. I'm going to quote some of my favorite passages and make analogies to the world of long-term care and assisted living.

Berkun writes extensively about workplace culture. He says, "If you ever wonder about why a family or a company is the way it is, always look up first. The culture in any organization is shaped every day by the behavior of the most powerful person in the room." This may be tough to hear for some leaders, maybe they just don't want this much responsibility. Consider what it's like to work in your facility. What qualities would you use to describe how people interact, how meetings are run, whether or not ideas are solicited and acted on, and the attitudes and behaviors that are allowed?

Every facility has a culture. Some are positive, supportive and innovative while others are strained, hierarchical, and rather negative. Perhaps it's a combination. Whether you like it or not, leadership sets the tone of the culture. Culture is imbedded in everyday processes from meetings, water cooler discussions, staffing, policies, to how staff treat each other and residents. Many times, staff don't know why things are a certain way, just that "it's always been this way." To this, Berkun goes on to say, "The problem with modern work, and one that sheds light on the future, is how loaded workplaces are with cultural baggage. We faithfully follow practices we can't explain rationally."

To help uncover irrational practices that might exist in your facility, consider these process-oriented questions:
1) Do you ever waste time waiting when you should not have to?
2) Do you ever redo your work because something failed the first time?
3) Do the procedures you use waste steps, duplicate efforts, or frustrate you through their unpredictability?
4) Is information that you need ever lost?
5) Does communication ever fail? (Berwick)

Berkun writes, "studying how a culture manages its problems is a powerful way to understand the culture." He advises that one way to evaluate a culture is to pick an issue, watch what happens and ask these questions: "How and where do issues get reported? Who responds? How long does it take? Who decides what issues are worked on first (triage)? Who does the actual work? Who checks to make sure it was done properly?"

How a culture responds to problems reveals who has the real power in the organization. Never assume, you might be surprised. Understanding how the system of people (*the culture*) works is critical for change, for improvement, to happen.

Sometimes leaders and managers bring remnants of a previous work culture with them – a form, a policy, a way of doing something – and with little to no consideration, expect to implement it in the new environment. They underestimate the power of the current, pervasive culture only to find that efforts at change are difficult at best and many times destined to fail. People inherently seek to maintain the status quo (even when it is not good), both deliberately and inadvertently. Berkun is wickedly honest when he says,

> A great fallacy born from the failure to study culture is the assumption that you can take a practice from one culture and simply jam it into another and expect similar results. Much of what bad managers do is assume their job is simply to find new things to jam and new places to jam them into, without ever believing they need to understand how the system – the system of people known as culture – works. Much like a frustrated moron who slaps the side of a TV when it stops working, taking action without understanding the system rarely helps.

Invest in the future of your facility and the staff; talk about the culture in your building. Use the questions in this article or come up with some of your own. What would staff like to see change? What works well? Just like with person-centered care for residents, emphasize strengths and strategize how to build on them. Talk with staff and really listen to what they have to say. It takes trust to share the unpleasant parts of any job with a leader so don't be surprised if they hesitate at first. And, keep in mind that if you choose to engage in these discussions, you must also be ready to act on what staff tell you.

In closing, I particularly like this statement, "The responsibility of people in power is to continually eliminate useless traditions and introduce valuable ones. An organization where nothing ever changes is not a workplace but a living museum." (Berkun) Berkun, S. The Year Without Pants and the Future of Work. San Francisco, CA: Jossey-Bass; 2013.
Donald Berwick editorial "Continuous Improvement as an Ideal in Healthcare" in the New England Journal of Medicine, December 1989. http://cds.web.unc.edu/files/2014/09/Berwick-1989.pdf.

Editor's Note: ***Join Paige Hector for her brand-new 60 minute webinar "Developing Care Plans: Resident Focused & Impactful" on Thursday, April 12th. Two presentations to choose from. You'll earn CEU credit for attending. Discover more details and register at WebinarLTC.com or call 800-807-4553.***

This educational offering has been reviewed by the National Continuing Education Review Service (NCERS) of the National Association of Long Term Care Administrator Boards (NAB) and approved for 1.25 clock hours and 1.25 participation hours

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http://www.mi-marr.org/LTC_toolkit.php

This toolkit is designed to help health care providers in long-term care facilities implement the 12 Steps to Prevent Antimicrobial Resistance Among Long-Term Care Residents, a set of recommendations developed by the Centers for Disease Control and Prevention (CDC) as part of its Campaign to Prevent Antimicrobial Resistance in Healthcare Settings. The toolkit follows the CDC 12-step framework and is divided into 12 sections, one for each step in the CDC Campaign. Strategies on how to break specific links in the chain of infection are included in each step, along with practical information, protocols, policies, and tools designed to be easily customized for specific facility needs.

Composite 8. Teamwork

1. Patient Safety Primer: Teamwork Training
https://psnet.ahrq.gov/primers/primer/8

Providing safe health care depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. The AHRQ's Patient Safety Network explains this topic further and provides links for more information on what is new in teamwork training.

2. TeamSTEPPS® Long-Term Care Version
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/index.html

Developed jointly by the Department of Defense (DoD) and the AHRQ, TeamSTEPPS® is a resource for training health care providers in better teamwork practices. The Long-Term Care version of TeamSTEPPS® adapts the core concepts of the TeamSTEPPS® program to reflect the environment of nursing homes and other long-term care settings such as assisted living and continuing care retirement communities.

Composite 9. Handoffs

1. **Cooperative Network Improves Patient Transitions Between Hospitals and Skilled Nursing Facilities, Reducing Readmissions and Length of Hospital Stays**
https://innovations.ahrq.gov/profiles/cooperative-network-improves-patient-transitions-between-hospitals-and-skilled-nursing

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. Summa Health System's Care Coordination Network strives to ensure smooth transitions between the hospitals and 37 local skilled nursing facilities, leading to fewer readmissions and lower length of stay in the hospital.

2. Interventions To Reduce Acute Care Transfers (INTERACT)
http://interact2.net

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

Composite 10. Communication Openness

1**. SBAR Technique for Communication: A Situational Briefing Model**
http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. This downloadable tool from the Institute for Healthcare Improvement contains two documents.

"Guidelines for Communicating With Physicians Using the SBAR Process" explains how to carry out the SBAR technique.

"SBAR Report to Physician About a Critical Situation" is a worksheet/script that a provider can use to organize information in preparing to communicate with a physician about a critically ill patient.

Composite 11. Nonpunitive Response to Mistakes

1. Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management
http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx
This tool was developed by the IHI. IHI periodically receives urgent requests from organizations seeking help in the aftermath of a serious organizational event, most often a significant medical error. In responding to such requests, IHI has drawn on learning and examples assembled from many courageous organizations over the last 15 years who have respectfully and effectively managed these crises.

Composite 12. Staffing

1. Consistent Assignment
https://www.nhqualitycampaign.org/goalDetail.aspx?g=CA#tab4

Advancing Excellence Campaign has identified best practices pertaining to consistent assignment. This Web site contains a collection of tools, guides, and resources to help nursing homes get started.

General Resources

1. 2015 Long Term Care National Patient Safety Goals
http://www.jointcommission.org/assets/1/6/2015_LTC2_NPSG_ER.pdf

The purpose of the Joint Commission Long Term Care National Patient Safety Goals is to improve patient safety in a long-term care setting by focusing on specific goals.

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SPRING WORD SEARCH PUZZLE

Find and circle all of the words that are hidden in the grid. The remaining letters spell a message about Spring.

T L E M W O N S S S A R G L A
G C Y C L A M E N S A L I L P
G N G R O W T H R L L L L R S
O Y I I D L S A R A I E S N N
L A L N K A I E B E R R O H E
F M L O A N F E S G M I P W W
E N A E E E S F I U L R R A L
I O B Q R A L E O E C S A B E
R S T U B E S C D D F O S W A
I A F I G R N N G L I N R H V
S E O N N R A E O N I L C C E
E S S O I D E W W B I R S B S
S I N X R G E E O A A R M E G
A Y F L P R O R N M L W P E O
E T E W S S P I L U T R S S R
R E T S A E P L A N T I N G F

ALLERGIES
APRIL
BASEBALL
BEES
CROCUSES
CYCLAMENS
DAFFODILS
DANDELIONS
EASTER
EQUINOX
FLOWERS
FROGS
GOLF
GRASS
GREEN
GROWTH
IRISES
LILIES
MARCH
MAY
NEW LEAVES
PLANTING
RAIN
RENEWAL
ROBINS
SEASON
SNOWMELT
SOFTBALL
SPRING BREAK
SPRING CLEANING
TULIPS
WARMER
WET

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2. Long-Term Care Improvement Guide
http://planetree.org/wp-content/uploads/2015/05/LTC%20Improvement%20Guide%20For%20Download.pdf

This guide was developed by Planetree, Inc., to propel long-term care communities in their improvement efforts by presenting a collection of concrete strategies for actualizing a resident-directed, relationship-centered philosophy. It supplies providers with tools, data, and practical resources so they can make informed decisions as they consider implementing culture change initiatives to deliver person-centered care.

3. Person-Centered Care
https://www.nhqualitycampaign.org/goalDetail.aspx?g=PCC#tab4

Advancing Excellence Campaign has identified best practices pertaining to person-centered care. This Web site contains a collection of tools, guides, and resources to help nursing homes get started.

4. Pioneer Network
https://www.pioneernetwork.net/Providers/ProviderTools/

Pioneer Network is a center for all stakeholders in the field of aging and long-term care whose focus is on providing home and community for elders. This Web site features tools, articles, and links for providers on culture change and quality improvement in nursing homes.

Please open the conversation between health care professionals and their patients to unite as members of the patient's health care team. Together, working as a team, and keeping lines of communication open, both providers and the patients can reduce harm and ensure the integrity of the care that is delivered. Here's to #PSAW2018!

Rebecca Adelman, PLLC, Esq. - Ms. Adelman is an entrepreneur and founding shareholder of Hagwood Adelman Tipton, PC and practices in the firm's Memphis, TN office. For nearly 30 years, Rebecca has concentrated her practice in insurance defense litigation representing national insurance carriers and self-insureds with a concentration in healthcare law. She also has an active business and employment practice. Please feel free to contact her at radelman@hatlawfirm.com or visit her website: www.rebeccaadelman.com and Instagram @rebecca_adelman

NAL Professional Not Coming Addressed to You Personally?

We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

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