

€ TRAINING

Understanding Organizational Culture For
Health Care Improvement



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Introduction:

Health policy in much of the developed world is concerned with assessing and improving the quality of health care. But how are quality improvements to be wrought in such a complex system as health care? A recent issue of Quality in Health Care was devoted to considerations of organizational change in health care, calling it "the key to quality improvement". In discussing how such change can be managed, and articles that cultural change needs to be wrought alongside structural reorganization and systems reform to bring about "a culture in which excellence can flourish". A review of policy changes over the past two decades shows that these appeals for cultural change are not new but have appeared in various guises. However, talk of "culture" and "culture change" begs some difficult questions about the nature of the underlying substrate to which change programs are applied.

Course Objectives:

At the end of this course the participants will be able to:

- Examine human factors and other basic safety design principles as well as commonly used unsafe practices such as workarounds and dangerous abbreviations
- Describe the benefits and limitations of selected safety-enhancing technologies such as barcodes, Computer
- Provider Order Entry, medication pumps, and automatic alerts/alarms.
- Delineate general categories of errors and hazards in care.
- Describe factors that create a culture of safety such as, open communication strategies and organizational error reporting systems.
- Describe processes used in understanding the causes of error and allocation of responsibility and accountability such as root cause analysis and failure mode effects analysis.
- Discuss the potential and actual impact of national patient safety resources, initiatives, and regulations.

Targeted Audience:

- Healthcare executives.
- Physicians.
- Nurses.
- Clinical staff.
- Industrial and management engineers.
- Laboratory and specialized healthcare services.
- Insurance company staff.
- Pharmaceutical staff.

Course Outlines:

Unit 1: Three Surveys on Patient Safety Culture Are Available:

- Nursing Home Survey on Patient Safety Culture.
- Medical Office Survey on Patient Safety Culture.
- Hospital Survey on Patient Safety Culture.

Unit 2: Health Care Organizations Can Use These Survey Assessment Tools To:

- Assess their patient safety culture.
- Track changes in patient safety over time.
- Evaluate the impact of patient safety interventions.

Unit 3: Teaching the Culture of Safety:

- Demonstrate prescribing, dispensing, and medication error vulnerabilities, and ways to avoid these vulnerabilities, during pharmacology classes.
- Evaluate the research on work hours and fatigue and discuss how these affect quality of care and risk of errors.
- Use unfolding case studies incorporating multiple QSEN.

Unit 4: Teaching the Culture of Safety:

- Observe and evaluate teamwork, communication, and collaboration during interprofessional rounds discussing patients.
- Discuss near misses and adverse events with staff nurses.
- Attend a Root Cause Analysis or a Failure Mode Effects Analysis meeting.
- Develop a safety rounds checklist and make unit rounds to complete the checklist.
- Share results with staff and initiate a discussion of the findings.
- Complete an environmental safety scan of a clinical area and evaluate space and lighting adequacy, as well as accessibility for patients, families, and staff.
- Assess traffic, noise, and accessibility of supplies and equipment including space for medication preparation.
- Work in teams including nursing, medical, and pharmacy student to examine a complex patient health record and complete a medication reconciliation analysis from admission through discharge.
- Design approaches to reduce interruptions.

Unit 5: Teaching the Culture of Safety Simulation Activities:

- Use a patient model to simulate safety breaches.
- Develop scenarios of various equipment failures and have participants detect and correct equipment problems.
- Demonstrate how a near-miss or error is documented.
- Use high fidelity clinical simulations to assess ability to deliver safe care in the clinical setting.