Vaccinations: Common Questions
&
Staff Morale PIP
&
Just Culture

Continuation Phase, Session 22

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Today

IHI Curriculum

- Vaccinations: Common Questions

Staff Morale PIP

- Share

Just Culture

- Natasha Green MBA, RN
  Quality Improvement Program Director

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1. How do you determine what information is relevant to your staff?

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2. What format do you use to present information to your staff?

How do you know if they have retained//understood the information presented?

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3. Do you model transparency in routine practice?

Is transparency part of your culture?

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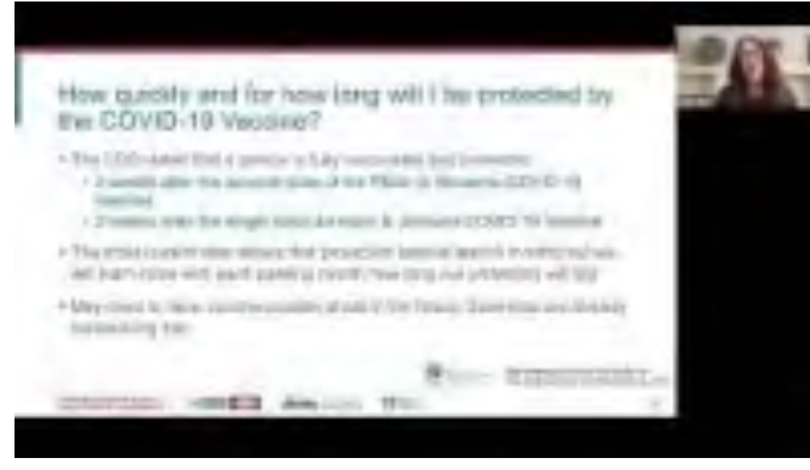
Video: Vaccinations – Common Questions



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Staff Morale

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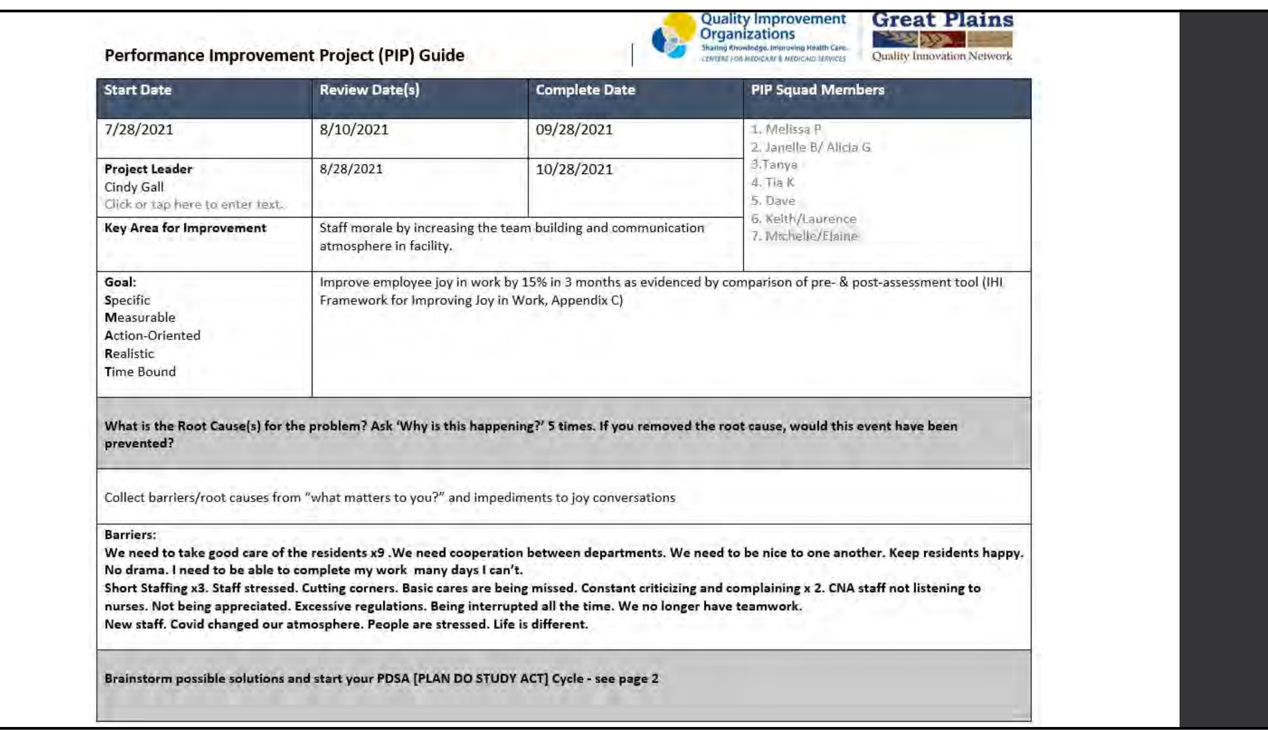

Performance Improvement Project (PIP) Guide

Quality Improvement Organizations — Sharing Knowledge. Improving Health Care. CENTERS FOR MEDICARE & MEDICAID SERVICES | Great Plains Quality Innovation Network

Start Date	Review Date(s)	Complete Date	PIP Squad Members
7/28/2021	8/10/2021	09/28/2021	1. Melissa P 2. Janelle B/ Alicia G 3.Tanya 4. Tia K 5. Dave 6. Keith/Laurence 7. Michelle/Elaine
Project Leader Cindy Gall Click or tap here to enter text.	8/28/2021	10/28/2021	
Key Area for Improvement	Staff morale by increasing the team building and communication atmosphere in facility.		
Goal: **S**pecific **M**easurable **A**ction-Oriented **R**ealistic **T**ime Bound	Improve employee joy in work by 15% in 3 months as evidenced by comparison of pre- & post-assessment tool (IHI Framework for Improving Joy in Work, Appendix C)		

What is the Root Cause(s) for the problem? Ask 'Why is this happening?' 5 times. If you removed the root cause, would this event have been prevented?

Collect barriers/root causes from "what matters to you?" and impediments to joy conversations

Barriers:
We need to take good care of the residents x9 .We need cooperation between departments. We need to be nice to one another. Keep residents happy. No drama. I need to be able to complete my work many days I can't.
Short Staffing x3. Staff stressed. Cutting corners. Basic cares are being missed. Constant criticizing and complaining x 2. CNA staff not listening to nurses. Not being appreciated. Excessive regulations. Being interrupted all the time. We no longer have teamwork.
New staff. Covid changed our atmosphere. People are stressed. Life is different.

Brainstorm possible solutions and start your PDSA [PLAN DO STUDY ACT] Cycle - see page 2

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Brainstorm:
Team identified that employees are missing the teamwork/communication our facility had prior to Covid.
We need to work on teambuilding education/exercises amongst Department heads and also staff.
Look into outside partner to come to facility to provide education on teambuilding.
Investigate teambuilding exercises that can be completed by dept heads.
Get Administration to support this.

Plan	Do			Study and Act	
List the tasks to be done	**Responsible Team Member**	**Start Date**	**Actual Completion Date**	**Comments/Lessons Learned**	**Adopt/Adapt/Abandon**
Meet as PIP team to develop charter (Review "Get Ready" action steps)	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Collect staff satisfaction surveys (e.g. Pinnacle)	Cindy G	August 2, 2021	August 6, 2021	18 of 20 surveys returned. Teambuilding and communication scores low.	Adopt
Launch conversations – (10 individuals) Appendix A – Conversation Guide	Cindy G	August 6, 2021	August 9, 2021	Interview 10 employees. All said teamwork/communication is a problem.	Adopt

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	Study and Act				
Benchmarks/metrics [how will we measure progress?]	**Baseline Date**	**First Measurement Date**	**Second Measurement Date**	**Final Measurement Date**	**Comments**
Pre-PIP & Post-PIP assessments (CMS Employee Satisfaction Survey)	8/2/2021-8/06/2021	8/2/2021	10/06/2021	Click or tap here to enter text.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	

This material was prepared the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 12SOW-GPQIN-13/0320

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Just Culture

People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of the individual; it is the fault of the system. Change the people without changing the system, and the problems will continue.

~Don Norman, Apple Fellow

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Just Culture

Is not a <u>blame-free</u> culture

Is not a <u>punitive</u> culture

It is an accountability culture

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Just Culture

Understands human fallibility and human behavior.

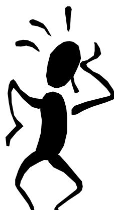
Designs systems for reliability to compensate for human error.

Supports a culture of learning.

Just Culture

Humans are accountable for their behavioral choices.

Response to errors depends upon behavior.



Three Behaviors We Can Expect

- **Human Error**—Inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake
- **At-Risk Behavior**—Behavior that increases risk where risk is not recognized or is mistakenly believed to be justified
- **Reckless Behavior**—Behavioral choice to consciously disregard a substantial and unjustifiable risk

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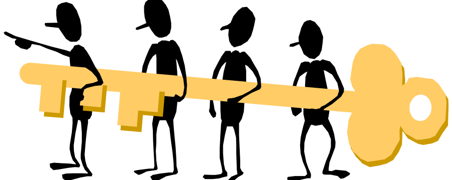
Just Culture

Creates a common understanding of how to treat people when things happen.



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Human Factors

The study of all the factors that make it easier for humans to do work the right way

We cannot change the human condition.
We can change the condition under which people work.
The design of things impacts how well we perform (workplace, tools, processes).
Work and processes need to be designed to be compatible with physical and cognitive abilities and limitations of human users.

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What Factors Impact Performance?

- Fatigue
- Lack of sleep
- Illness
- Drugs or alcohol
- Boredom
- Frustration
- Fear
- Stress
- Shift work
- Reliance on memory
- Reliance on vigilance
- Distractions
- Noise
- Heat
- Clutter
- Motion
- Lighting
- Too many handoffs
- Unnatural workflow
- Procedures or devices designed in an accident-prone fashion

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Error Reduction Strategies

- Avoid reliance on memory
- Simplify
- Standardize
- Use constraints/forcing functions
- Use protocols and checklists
- Improve information access
- Reduce handoffs
- Increase feedback
- Decrease look-alikes
- Automate carefully
- Take advantage of habits and patterns

- **These are the interventions that lead to improvement projects!**

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Case Study

Description: An infant born with sluggish breathing is given Lanoxin® instead of naloxone, and dies of digoxin toxicity

What could have been done to prevent this error?

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A Learning Culture

Sees events as opportunities to improve our understanding of risk

- System Risk
- Behavior Risk

Investigates the source of errors and at-risk behaviors

Design and redesign systems to reduce risk

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Questions?

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Staff Morale Homework

$50/ submission

- Meet as PIP team
- Review "Change Ideas" (Appendix B) &/0r "Conversation & Action Guide to Support Staff Well-being & Joy in Work During & after COVID" & compare to the "What Matters to You" conversations
- http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
- http://www.ihi.org/resources/Pages/Tools/Conversation-Guide-to-Support-Staff-Wellbeing-Joy-in-Work-COVID-19.aspx
- Identify one change idea to trial
- Start PDSA trials

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If you would like additional technical assistance, please let us know.

You can work with our mentors one-on-one.

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