

Medication Safety Issue Brief

Change Your Culture Forever

3

of 6 in a series

Series II

Sustaining medication safety change is the focus of part three in a six-part series designed to help senior managers reduce preventable patient harm in their hospitals. This series of six issue briefs was developed by the American Hospital Association, the American Society of Health-System Pharmacists and *Hospitals & Health Networks* with the generous support of Aventis Pharmaceuticals. You may tear out this card for future reference. Additional copies of both an earlier series, published in 2001, and this series are available in PDF versions on the ASHP and *H&HN* Web sites (www.ashp.org and www.hhnmag.com). ASHP members can also call the ASHP's fax-on-demand service.

• SUMMARY

What is it they say about the best-laid plans? They often go awry. It's the same with initiatives to make drug delivery in hospitals safer. An organization can analyze its procedures with the most sophisticated methods and squeeze out every possible chance for error, but the new design will mold with disuse if momentum is lost. There are many ways for an innovation to get derailed: lost enthusiasm, personnel changes, budget cuts. As they mature in the safety process, organizations have to be flexible but also stay firm in maintaining medication safety as a top priority. Keep safety initiatives alive by involving staff, "hardwiring" changes into the system and monitoring their progress well into the future.

• ISSUE BRIEF

Through the Institute for Healthcare Improvement's initiative to improve medication safety in hospitals, Terri Simmonds has helped many hospitals initiate change. Sustaining that change can be just as difficult. "You can design a wonderful drug protocol and say, 'Here you go,' but if [staff members] don't own it, it sits there unused," says Simmonds, director of the patient and medication safety collaboratives for Boston-based IHI. "Once a change has been tested and implemented you have to figure out how to hardwire it into your system."

One easy way to hardwire is through prompts and reminders in electronic systems. But organizations that haven't bought into computerized physician order entry or bar coding systems can make updated procedures part of the system by embedding them into policies and procedures manuals, orientation for new employees, job descriptions and employee reviews. Some hospitals are experimenting with ways to automate those procedural updates in manuals to save time and avoid confusion.

It would be nice if all it took for clinicians and staff to change how they handle a process is to issue a memo or hold a training session. "You think if you put the conceptual model out there, people will just get it, and that's naive," says Vicki Crane, vice president of pharmacy and material services for Parkland Memorial Hospital, Dallas. "In fact, it takes a lot of hand-holding and explanation. It means integrating it into every aspect of what you do with employees, into orientation and training."

As many organizations are learning, culture often trumps a great procedure. So the best place to embed new ideas is in the heads and hearts of clinicians and staff. "It boils down to



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ACTION Agenda

Here is a list of action items you can use to sustain change within your organization:

- Hardwire changes so they outlive individual staffers: add to orientation, policies and procedures, job descriptions and reviews.
- Involve those who work with a system at the outset so they come to “own” the new process.
- Educate in a variety of ways and repeatedly; don’t assume one message is enough for long-term change.
- Offer visual reminders.
- Plan reviews of important process changes at six-month or yearly intervals in perpetuity.
- Follow the numbers—track and trend errors and make review of those data regular agenda items for medication safety group meetings.
- Finally, it may sound trite but it’s the bottom line: make patient safety a personal priority for everyone in the organization, particularly those at the top, and don’t let that change.

ADDITIONAL RESOURCES

- Qualityhealthcare.org is a Web site that offers specific safety and quality improvement ideas and a chance to network with other organizations trying the same things.
- The Institute for Healthcare Improvement is starting a collaborative on improving patient safety this fall. For information, visit www.ihl.org/collaboratives/breakthroughseries/PatientSafety/index.asp.
- Pathways for Medication Safety project, American Hospital Association, lists specific tools for hospital leaders at www.hospitalconnection.com/medpathways/tools/tools.html.

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integrating it into the fabric of the organization,” Simmonds says. “People who are using the new process or protocol really have to feel as though they own it.”

Parkland has found it useful to maintain an active medication safety group with representation from around the hospital and an open atmosphere to discuss potential problems and course corrections. “You have to have a safe environment where you can do some goal-setting,” Crane says.

Many organizations collect data about new initiatives to determine if they are successful. But ongoing monitoring can keep those changes from fading into obscurity. At Lehigh Valley Hospital, Allentown, Pa., medication processes are typically measured before and after an improvement, and then reviewed at six months and a year later with a small percent sample, says Fred Paine, pharmacy services administrator.

Continued attention from top administrators can also keep medication safety on the front burner. Iowa Health System, Des Moines, found that at the hospital where executives did safety walkrounds three times as often as at the other hospitals, employee “culture of safety” survey results were much stronger.

Including patient safety in strategic planning and budgeting is another useful way to keep those issues competing successfully for time, attention and money at the top level of the organization, Crane says. “When you have the CEO and chief operating officer and top physicians and top administrators involved, that’s when you can get things done.”

• CASE STUDY

Iowa Health System, Des Moines: Eleven-hospital Iowa Health System has a comprehensive drug safety program that’s spearheading a host of initiatives. Along with those changes are plenty of opportunity for employees to stay involved, says Gail Nielsen, patient safety administrator. For instance, employees are surveyed each year on their views of the system’s nonpunitive approach to errors and executives’ involvement. On the floors, each unit takes time out regularly to discuss safety and processes. When staffers point out a problem or propose a great fix, they get feedback. Patient safety is seen as an ongoing effort, not a one-time training session. To hold onto gains made by safer procedures, Nielsen says, “I started asking my teams, ‘What have you hardwired this month?’ At first they struggled to give me answers, but now it’s easier.”

Simple visual reminders have been helpful in sustaining process change at one of the system’s hospitals. Nurses would hang an IV bag ahead of time but forget to come back and open the clamp, Nielsen says. So they made up humorous, colorful reminder signs whose design changed regularly. In another case, staffers found that gait belts helped patients walk who were unsteady on their feet after orthopedic surgery, but they could never find a belt when they needed one. So they bought one for every patient and hung them in the doorways. ●

