Organizational Culture and Change Management

TeamSTEPPS Master Trainer Workshop

Master Trainers
1. Know the team strategies and tools
2. Role model, teach, coach, team strategies and tools
3. Implement action plans to use the team strategies and tools to solve clinical problems
4. Manage culture change as you implement action plans

Objectives: Managing Culture Change
1. Explain the concept of safety culture (what are you trying to change?)
2. Use an explicit strategy to manage culture change
Objective 1.
Explain the concept of safety culture

• Definition
• 4 Categories of Culture
• 3 Levels of Culture
• 4 Components of Culture
• Role of Organizational Culture
• Role of Leadership in Organizational Culture

What is a Safety Culture?

• LEARNED,¹ enduring, shared, beliefs and behaviors that reflect an organization’s willingness to learn from errors²

• Patient safety has a high relative importance to other organizational goals (i.e. productivity)³

• Four beliefs present in a safe, informed culture⁴
  1. Our processes are designed to prevent failure
  2. We are committed to detect and learn from error
  3. We have a just culture that disciplines based on risk
  4. People who work in teams make fewer errors

Four Categories of Culture¹

1. Macroculture
2. Organizational Culture
3. Microculture
4. Subcultures within Positions

14 clinics each have their own culture
Three Levels of Organizational Culture

“...values reflect desired behavior but are not reflected in observed behavior.” (Schein, 2010, pp. 24, 27)

| Behaviors | Observed Communication Behavior: 29% agree, “Staff feel free to question decisions or actions of those with more authority.” |
| Beliefs & Values | Belief: Belief about Communication: 60% agree, “Staff will speak up if they see something that will negatively affect patient care.” |
| Underlying Assumptions | Assumption: Safety is a system property but I will be attached if I speak up. Staff and providers should work together as a team to achieve results (patient safety and clinical outcomes) |

Four Components of Safety Culture

1. Reporting Culture
2. Just Culture
3. Flexible (Teamwork) Culture
4. Learning Culture

- Effective reporting and just cultures create atmosphere of trust
- Sensemaking of patient safety events and high reliability result from an explicit plan to engineer behaviors from each component of safety culture

Crosswalk Reason’s Components

<table>
<thead>
<tr>
<th>Reason’s Components</th>
<th>HSOPS Dimension or Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Culture - a safe organization is dependent on the willingness of front-line workers to report their errors and near-misses</td>
<td>Frequency of Events Reported (U)</td>
</tr>
<tr>
<td></td>
<td>Number of Events Reported (O)</td>
</tr>
<tr>
<td>Just Culture - management will support and reward reporting; discipline occurs based on risk-taking</td>
<td>Nonpunitive Response to Error (U)</td>
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O=Outcome Measure, U=Unit, H=Hospital
### Crosswalk Reason’s Components

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<td>Flexible Culture</td>
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<tr>
<td>• Authority patterns relax when safety information is exchanged because those with authority respect the knowledge of front-line workers</td>
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</tr>
<tr>
<td>Learning Culture</td>
<td></td>
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<tr>
<td>• Organization will analyze reported information and then implement appropriate change</td>
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### The Role of Organizational Culture

**Organizational Culture**
- Allows us to make sense of environment
- Reflects common language... is heard and observed
- Leaders create/teach culture
  - Share information
  - Reward, provide feedback
  - Hold people accountable

**Safety Culture**
- A cross cutting contextual factor
- Moderates effectiveness of patient safety interventions
- Associated with adverse events and patient satisfaction

### Leaders Engineer Culture

“...it is the unique function of leadership to perceive the functional and dysfunctional elements and to manage cultural evolution and change.”

The Bottom Line…

Improving safety culture increases likelihood of success of all other patient safety interventions.

Objective 2.

Use an explicit strategy to manage culture change
1. Kotter’s Eight Steps of Change
2. Comprehensive Unit Based Safety Program (CUSP)
3. Diffusion of Innovations

Why Does Change Fail?

Why isn’t the US on the metric system?

http://static.ddmcdn.com/gif/us-metric-system-1.jpg
Why Does Change Fail?
Share examples from your setting

Multiple Strategies for Change

1. Kotter’s Eight Steps of Change\textsuperscript{10}

- Get people’s attention (with stories and data!)
  - MOS results, harmful events, issues with waste of time/resources, patient satisfaction, core Measures
- Sell the need for change… and the consequences of not changing to administrators, clinic leaders and managers, clinic providers and staff
- Immerse clinic staff in information about the change
- Empower people to solve problems associated with the change

1. Create a Sense of Urgency\textsuperscript{10}

- MOS results, harmful events, issues with waste of time/resources, patient satisfaction, core Measures
- Sell the need for change… and the consequences of not changing to administrators, clinic leaders and managers, clinic providers and staff
- Immerse clinic staff in information about the change
- Empower people to solve problems associated with the change
2. Build the Guiding (Change) Team

- Include proven leaders who can drive the change process
  - Formal power with high credibility
  - Informal opinion leaders
  - Interprofessional
  - Set expectations for follow through

- Need management and leadership skills
  - Management skills control the process and details
  - Leadership skills drive the change with a vision

...TeamSTEPPS initiative should have a designated executive/leadership sponsor

3. Develop the Change Vision and Strategy

- Work with leaders to define and communicate your vision for change...
  - Defining a culture of safety aligned with expectations, core values, shared beliefs
  - Informing the clinic of these values and evaluating the culture
  - Leading the process of:
    - Translating values into expected behaviors
    - Establishing trust and accountability
  - Share how this change is consistent with mission and core values

4. Communicate for Understanding & Buy-In

- Includes education and training
- Encourage discussion, dissent, disagreement, debate ... keep people talking
- Tell people what you know—and what you don’t know
- Value resisters (NO NO)
  - They clarify the problem and identify other problems that need to be solved first
  - Their tough questions can strengthen and improve the change
  - They may be right—it is a dumb idea!

...communicate, communicate, communicate...
4. Communicate Using Talking Points (Data & Stories)
It is important to improve teamwork in our organization because:
• 1/4 of our nursing staff believe that shift changes are problematic for patients
• 2/3 of our clinical staff do not feel psychologically safe speaking up to those with more authority when patient safety is at stake
• Only ½ of the staff in the ED agree that there is good cooperation among hospital departments that need to work together.
• RCA identified poor communication during a handoff of a patient from floor to radiology that led to a fall
• Lack of using check-back in a code situation may have contributed to a patient death

5. Empower Others to Act
• Train employees so they have the desired skills and attitudes
• Identify personnel with the vision and skills to COACH others
• Manage high-level resisters...how does professor manage NO NO?
http://www.kotterinternational.com/our-principles/our-iceberg-is-melting
An organization cannot be improved from the top only

6. Produce Short-Term Wins
• Provide positive feedback (shirts, pins)
  – Further builds morale and motivation
  – Results from debriefs
• Provide feedback to plan next goal
• Create greater difficulty for resisters to block further change
• Provide leadership with evidence of success
7. Don’t Let Up

- Evaluate your training sessions and learn from the evaluations (form on website)
  http://www.unmc.edu/patient-safety/teamstepps/toolkit.html
- Reaffirm the vision
- Celebrate successes and accomplishments
- Orient new employees to the tools
- Include in annual training to reinforce behaviors (Overview on website)
- Communicate, communicate, communicate
- Stay connected to TeamSTEPPS communities (your 14 clinics, UNMC, National Implementation)

8. Create a New Culture

- Hard wire the change
  - Job descriptions
  - Performance evaluations
  - Policies/procedures
- Use language and tools in clinical and nonclinical settings
  - Managers use the tools
  - Leaders call for briefs, huddles, and debriefs
  - All monitor the situation to establish situation awareness
  - All seek and offer task assistance
  - All structure communication with SBAR, Call-out, Check-back and I PASS the BATON
  - All structure email communication, document reviews, requests for maintenance with SBAR

TeamSTEPPS...Innovation to Address Need

2. Comprehensive Unit Based Safety Program (CUSP)

Innovation: An idea or practice that is perceived as new

Diffusion process: Innovation is communicated through channels over time among members of a social system

TeamSTEPPS Strategies and Tools to Enhance Performance and Patient Safety
Getting a new idea adopted, even when it has obvious advantages, is difficult. Many innovations require a lengthy period of many years from the time when they become available to the time when they are widely adopted.  

Attributes of Innovations

General Attributes
- Relative advantage
- Compatibility
- Complexity
- Trialability
- Observability

TeamSTEPPS
- Train-the-Trainer
- Fundamentals
- Essentials
- Coaching
- Culture Assessment
- Implementation/Action Planning

Characteristics of Innovative Organizations/Individuals

Organizations
- Management supportive
- Resources available
- Implementation practices “hard wired”
- Champions
- Fit between innovation & values
- Effective innovation improves culture/climate

Individuals
- Greater contact with change agents
- Actively seek information
- Greater knowledge of innovation
- Greater social participation
## TeamSTEPPS

### Organization Innovation Process

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<tr>
<th>Initiation</th>
<th>Decision</th>
<th>Implementation</th>
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<tbody>
<tr>
<td>Agenda Setting: Identify need to improve (performance gap as a trigger)</td>
<td>Matching: Find an innovation to meet need and bridge performance gap</td>
<td>Redefining/Restructuring: Re-invent innovation to match context, restructure organization to fit innovation</td>
</tr>
<tr>
<td>Clarifying: Make roles and tasks associated with innovation clear</td>
<td>Routinizing: Innovation is hard-wired into organization's policies/procedures</td>
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### Individual Innovation Process

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<tr>
<th>Pre-Contemplation</th>
<th>Preparation Action</th>
<th>Maintenance</th>
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<tbody>
<tr>
<td>Knowledge: Recall information, knowledge &amp; skill for effective adoption</td>
<td>Persuasion: Like the innovation, discuss with others, form positive perception</td>
<td>Decision: Intent to seek additional information and to try innovation</td>
</tr>
<tr>
<td>Implementation: Acquire additional information and use innovation on regular basis</td>
<td>Confirmation: Recognize benefits of using innovation, integrate into routine, promote to others</td>
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### Change Management: Putting it All Together

<table>
<thead>
<tr>
<th>Stages (Kotter)</th>
<th>Change Model (Pronovost)</th>
<th>Organizational Stages (Rogers)</th>
<th>Individual Stages (Rogers)</th>
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<tr>
<td>Create Sense of Urgency</td>
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<td>Communicate for Understanding</td>
<td>Educate</td>
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<td>Empower Others</td>
<td>Execute</td>
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<td>Decision</td>
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<td>COACH</td>
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<td>Short-Term Wins</td>
<td>Execute – Evaluate</td>
<td>Clarifying - Routinizing</td>
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<td>Don’t Let Up</td>
<td>Evaluate – Expand</td>
<td>Clarifying - Routinizing</td>
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<td>Create a New Culture</td>
<td>Expand – Endure</td>
<td>Routinizing</td>
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Putting it All Together: The Checklist

- Clearly define the change
- Management is supportive
- Implementation Champion
- Employees recognize change is a priority
- Resources are available
- Policy/Procedure changed
- Job descriptions/performance appraisals changed
- Change is evaluated
- Results of evaluation guide improvement


Culture Change Comes Last, Not First!10

- Changes in values come at the end of the transformation process
- New behaviors adopted by the laggards after success has been proven by the early adopters
- Feedback and reinforcement are crucial to adopting the behaviors
- Sometimes the only way to change culture is to change key people
- Individuals in leadership positions need to walk the walk and talk the talk

...Reculturing takes time and it really never ends

Role of Leaders in Transformational Change

- Create a compelling positive vision
- Concretely define the goal as a performance problem...not “changing culture”
- Ensure new behaviors are formally taught in groups
- Ensure new behaviors are reinforced
  – Provide opportunities for practice, coaching, feedback
  – Be a positive role model
- Create structures consistent with new way of thinking/working/behaving

Summary

- Safety culture is the learned, shared beliefs and behaviors that reflect organization’s willingness to learn and whether safety is a priority.
- There are multiple strategies to use an innovation such as TeamSTEPPS to change your culture; they all have common elements…
  - Urgency/Engagement/Agenda Setting…the reason to change
  - Develop the right team to guide the change; make sure they have the time and resources to do the work
  - Match a specific problem to a solution and communicate the vision! (targeted or transformational change)
  - Empower, clarify, make it routine…don’t give up!
  - Expect barriers and manage them!

References