Quality Improvement Basics: A Culture of Quality

Slide 1 Objectives

After completing this module, participants will be able to:

- Understand the importance of embedding a culture of quality in a health care organization
- Describe success factors for developing and supporting a culture of quality in a health care organization
- Explain the concept of just culture and its importance in establishing a culture of quality

Slide 2 Culture of Quality Success Factors

We've defined organizational culture as how we do our work and behave and interact with each other. Organizational culture reflects shared values, patterns of belief, and expectations that guide the behaviors of the individuals that make up the organization.

An organization committed to quality improvement does not treat quality as the work of one department or as an afterthought; rather, the principles of quality improvement are the way the work is done. In other words, the organization has embedded quality improvement into their organizational culture. A leader can't write a memo and say, "we now have a culture of quality"—it's not that easy because culture is a collective characteristic, determined by those who are part of it. Seven success factors for a culture of quality are offered here

- leadership engagement
- systematic processes
- flexibility
- expectations that prioritize quality improvement
- fairness and accountability
- involving internal and external customers, and
- celebrating wins.

Throughout this module we'll consider each of them and how together they support a culture of quality.

Slide 3 Leadership Engagement

It's essential to have leadership for quality in the form of visible commitment, resource allocation, and accountability throughout the organization.

Individuals in formal positions of authority must personally model the behaviors and commitments expected of team members. This might be members of a board of directors, a CEO, an administrator, clinic manager, and so on. People in the organization and throughout the community closely watch to see that leader's actions match their words.

Where are resources going (and not)? How are staff and clinicians reviewed and rewarded? Are staff allotted the necessary time to effectively engage in quality improvement? What takes priority in training and development opportunities? It's not just lip service... people will know if there is not a genuine commitment to quality.

And while leaders recognize that systems drive results, they also hold others accountable for the quality expected in an organization.

Slide 4 Systematic Process for QI

A culture of quality requires a systematic approach to quality improvement. It is so helpful when everyone is speaking the same quality language and using a shared approach to quality improvement work, such as the Model for Improvement or another model or framework that you've adopted. Adopting systemic processes make it easy for people by providing appropriate training, easy to use templates, resources needed for improvement, and ensuring a transparent flow of information so that everyone affected by the change is informed and involved.

Slide 5 Flexibility

Sometimes folks can think of quality improvement as being rigid. There is a place for defining processes and reducing variability, but flexibility where appropriate is also important. Be creative in how quality improvement work is allocated – a key idea here is to assign project team members and leads based not only on needs and capabilities, but also based on interest. Open up the project planning and implementation process to engage a wide variety of staff. And when adopting strategies for your organization, do what makes sense based on your organizational needs and staff capabilities. While there are basic principles of quality improvement that apply in every health care context, the way the work is organized and implemented is not one-size fits all. For example, the quality improvement infrastructure of a large health system with multiple tertiary hospitals, specialty clinics, and thousands of staff will look different than a small critical access hospital. And that's ok. Do what makes sense for your organization.

Slide 6 Expectations that Prioritize Quality

At all levels of the organization, including the CEO and the board of directors or trustees, the expectation for quality should be clear. There is a LOT going on in health care organizations, and safe, equitable, and quality patient care is the priority, but it's important to ensure that quality doesn't get lost in the shuffle...on the contrary, quality is what fosters excellent patient care. Sometimes we can get so busy that we don't find time to assess our work and related outcomes in order to make improvements. The saying of being "too busy chopping wood to sharpen the axe" comes to mind. The point being if we make time to prioritize quality improvement, we enhance patient care. And remember that a commitment to quality always requires a commitment to health equity – there is no quality without equity.

Slide 7 Fairness and Accountability

For quality improvement to be successful in supporting quality of care and safety, organizations must balance fairness and accountability.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $740,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (June 2023)

Everyone in the organization needs to feel safe to share mistakes, complaints, concerns, or potential risks. Feeling safe means not fearing punishment for identifying a problem or admitting a mistake.

Why is this important? Because we learn from our mistakes. If people are afraid to describe mistakes, the mistakes are perpetuated. Mistakes are often a tip off to something wrong in the way the work is structured.

When we balance fairness and accountability, we create a fair and open environment in which there is understanding that the system impacts human behavior and performance. This way of thinking requires looking at systems and processes and the impact on individual performance with an understanding that problems generally arise from the impact of our systems and processes on individual behavior and performance. Individuals are accountable for their actions but not the errors or mistakes that are the result of system problems.

An important way to achieve this is to embrace a Just Culture.

Slide 8 What is 'Just Culture'?

So, what is just culture?

Just culture is a model that recognizes it is both the design of our systems and processes AND the choices and behaviors of the humans working within those systems that produce outcomes.

The model incorporates what has been learned about system design, human free-will, and human fallibility. The foundation of a just culture is safety. All people have the duty to avoid causing unjustifiable risk or harm to others, but all humans are also fallible and will make mistakes. In healthcare, our systems and processes are designed by and include humans, so are susceptible to failure or error.

It is the duty and responsibility of the organization to consider humans factors and to design systems and processes that minimize the risk of error and make it easy for staff to perform safely, effectively, and efficiently. Knowing that these types of errors can and do exist should be taken into consideration during our quality improvement work.

Just Culture looks at how we create and communicate expectations for our organization and individuals around systems and processes. In a Just Culture, all staff are accountable for their own behavior and choices and for reporting errors, near misses, and areas of risk. The organization and its leaders are responsible for designing safe and effective systems and processes and also for responding to staff behavior and choices fairly and justly.

Slide 9 Just Culture – Five Behaviors

The Just Culture Company model categorizes human behavior into five categories and responds to each accordingly. The behavioral categories are: Human Error, At-risk Behavior, and Reckless Behavior, Knowledge, and Purpose.

- **Human Error** – is an inadvertent slip, lapse, or mistake.
    - Example: knocking over a glass of water, dropping an open bottle of medication

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $740,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (June 2023)

    - It is managed through accepting the error and consoling the individual by acknowledging the event and the emotions of the employee while identifying opportunities to improve process and system design
- **At-Risk Behavior** – is a choice to act but risk to others is not recognized or is believed to be justified; these may be short cuts or routine rule violations that have become normalized.
    - Example: not performing a time-out procedure properly because "we do this all day every day and we've never had a problem"
    - At risk behavior is managed through coaching the individual(s) to recognize risk in real time and to comply with procedures and policies for safety
- **Reckless Behavior** – is a choice to act that includes conscious disregard of substantial and unjustifiable risk; however, the negative outcome is not certain.
    - A classic example of this is reckless driving – while there is substantial or unjustifiable risk, it's not certain there will be a negative outcome
    - Reckless behavior is managed through disciplinary action
- **Knowledge** – is knowingly cause harm.
    - Example: theft or diversion of a patient's pain medication – a person is knowingly causing harm and choosing themselves over others
    - Sometimes knowingly causing harm can be justified – such as trespassing to save someone in danger.
    - If the harm is deemed unjustified, these kinds of behaviors are managed through disciplinary actions
- **Purpose** – actions with an express goal to cause harm.
    - Example – malicious social media posts or other actions with the intent to cause physical, emotional, or property damage
    - Managed through disciplinary action usually including termination

In all cases, behaviors must be assessed independent of the actual outcome. If you're interested in learning more about Just Culture, check out the Just Culture Company.

Slide 10 Involving Internal and External Customers

Engaging (the voice of) customers, both internal and external, is a key concept in quality improvement.

Customers can include

- patients, families, and community
- payers or other funders
- partner care providers that you work closely with in coordinating patient care
- And internal customers such as staff across different departments

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $740,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (June 2023)

Know who your customers are and involve them in QI efforts in order to meet or exceed their expectations. Common strategies for engaging patient, family and community include establishing patient and family advisory committees, inviting patient representatives to participate in quality committees, gathering feedback including satisfaction, and ensuring diverse community perspectives are represented on the board of directors or trustees. Collaborative efforts with partner care providers can be a way of identifying pain points for patients and working together to improve outcomes.

Slide 11 Celebrate Wins

While there is work to do, there is much to celebrate.

Be sure to celebrate and recognize wins, big and small, not only within your health care organizations, but with your partners and across the community.

This will help people to feel appreciated and keep them engaged in the work going forward.

Celebrating can take many forms. It could be as simple as saying thank you or writing someone a note or something larger like a department party involving food and fun.

Slide 12 In Summary

- Organizations committed to quality do not treat it as a separate to do – they embed a culture of quality throughout the organization so that quality becomes the way work is done, not an add on.
- Key factors that drive a successful quality culture include leadership engagement, systematic processes for QI, flexibility, expectations that prioritize QI, fairness, and accountability, meaningfully involving customers, and celebrating wins.
- Just Culture is a workplace principle of accountability. In a Just Culture, the organization and its leaders are responsible for designing safe and effective systems and processes and also for responding to staff behavior and choices fairly and justly. Employees are held accountable for their choices and for reporting safety concerns. A Just Culture addresses root causes that lead to an error to prevent it from happening again.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $740,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (June 2023)