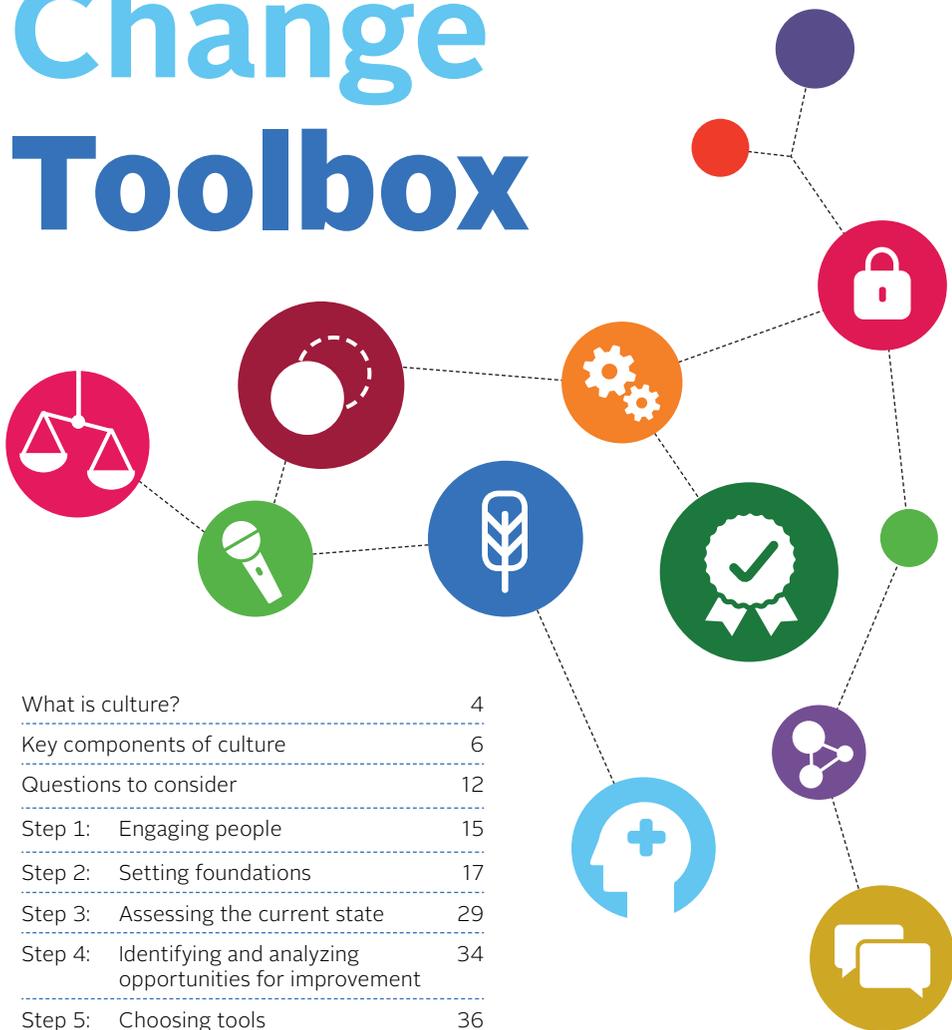


Culture Change Toolbox



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TOOLS

There are many techniques that can be used to improve culture and ignite change.

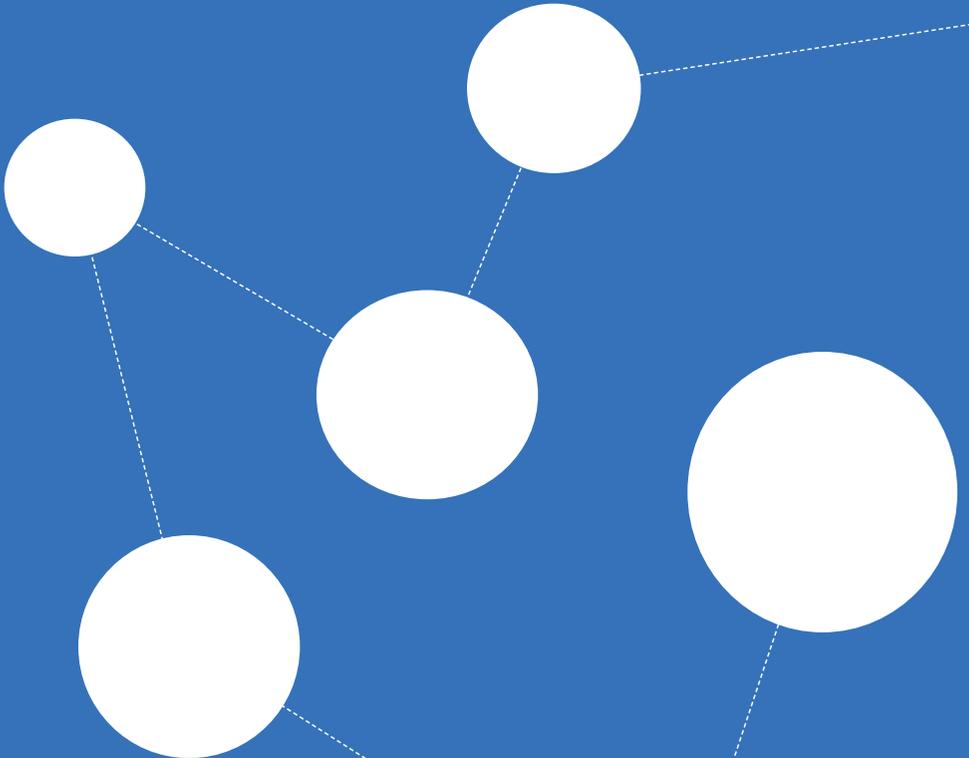
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Cultural Safety	Trust	Transparency	Teamwork & Comm.	Working Conditions	Safety Climate



SUMMARY

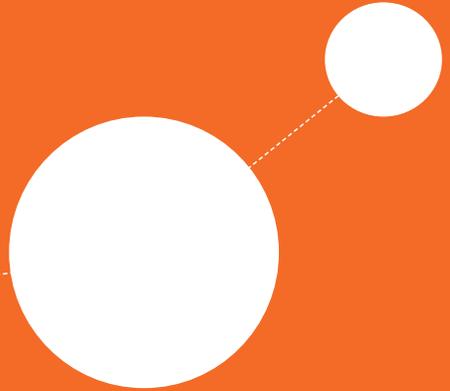
Culture is the way we work together. As we all know, in many work environments, there are opportunities to improve culture. While this may seem like a daunting task, the good news is that we all, individually and collectively, have the power to do it. This guide outlines the steps that we can take to shift culture in health care: engaging people, setting foundations, assessing the current state, identifying and analyzing opportunities, choosing tools, and testing changes. We invite you to start the journey.



WHAT IS CULTURE?

Culture is the way we think — our values, our attitudes, our perceptions and our beliefs. It's also how we act — our habits and our typical behaviours.

It's not about one person; it's about all of us. Culture is the beliefs we share, what we expect of each other, what's considered normal and the way we behave. Ultimately, it determines how our organization functions. It's "the way we do things around here."



HOW WOULD YOU DEFINE CULTURE WHERE YOU WORK?

Every organization, and every team within it, has its own culture. We may think we aren't able to influence culture individually but we have more influence than we think! Each of us shapes culture by how we interact with others, how we respond, and how we behave.

For example, we may pick up the habits of a workplace when we arrive in order to fit in and get the work done, but we are often unaware of how these habits formed in the first place. By examining our current practices and culture, we can start to understand why things are the way they are and begin to explore new ways of working together.

...THINK ON THIS

THE IMPORTANCE OF CULTURE

Better culture means better outcomes for our patients and fewer adverse events. In an analysis of more than 4,000 adverse events, the Joint Commission identified communication breakdown as the most common cause.¹ Evidence is growing that shows a concrete link between strong teamwork and increased safety and quality of care.^{2,3}

Interventions that improve culture can change clinical outcomes for the better and reduce adverse events.⁴

Equally as important, a better culture has been shown to improve the psychological health of providers and increase engagement and satisfaction at work. A strong team culture is linked to improved job satisfaction, commitment and productivity.⁵ A weaker or more stressful team culture is associated with more near miss events, distrust, and frustration.⁶

In the end, a healthier culture benefits both patients and providers.

**TEAMWORK &
COMMUNICATION**

**ORGANIZATIONAL
FAIRNESS**

TRANSPARENCY

**SAFETY
CLIMATE**

**CULTURAL
SAFETY**

KEY COMPONENTS OF A STRONG CULTURE

When working towards building a strong culture, it is important to consider all the components that make up culture. Like cogs in a machine, each of the components is integral to team success and having a strong cultural foundation. If even one element is weak or missing, it can affect the team's performance.

LEADERSHIP

**JUST
CULTURE**

**WORKING
CONDITIONS**

TRUST

**PSYCHOLOGICAL
SAFETY**



ORGANIZATIONAL FAIRNESS

Organizational fairness means that everyone is treated respectfully and organizational practices support considerate interactions between team members, including:

Respectful behaviour and the absence of intimidation or discrimination.

Team members are supported and encouraged to grow and develop.

Advancement in the organization is fair.

These factors are major contributors to job satisfaction and morale. When job satisfaction is low, performance is reduced and turnover is likely to be high. Ensuring organizational fairness is not easy and it requires active leadership. Leaders may need to look at conflict management and the application of fair workplace policies. However, it is not a job for formal leadership alone. Fairness is realized when all team members walk the walk and are supported by all leaders in doing so.



LEADERSHIP

In a positive safety culture, leaders are dedicated to patient safety, support point of care providers in their day-to-day work, address individuals that cause problems for others, and share information that affects the work of providers in a timely and transparent manner.

When perceptions of leadership are poor, providers don't think leadership is particularly concerned about their well-being or patients' well-being. Leadership has a strong impact on morale and culture overall.

The number one change to improve perceptions of leadership is to increase the visibility of leaders. One way to do this is through Leadership Walkarounds (see page 44). Visible leadership helps build trust by engaging in meaningful dialogue about issues which concern everyone. Other examples of visible leadership include attending huddles, asking and acting upon feedback from staff, and role modeling positive actions for staff.



PSYCHOLOGICAL SAFETY

Psychological safety refers to the ease or comfort to speak up, share ideas, give input or ask questions. Unless we can reduce the anxiety people feel when faced with risk, they may be reluctant to discuss issues that affect patient safety.⁷ Psychological safety has two main components:

1. The degree to which people feel their comments and contributions are met with respect by others throughout the organization.
2. The visibility and transparency of communication. To help ensure psychological safety, we must first create opportunities to give comments and contributions. Start with low-risk opportunities if the current psychological safety is low. The most powerful way to show that contributions are valued is to follow up! A positive response to a comment can open the door for future contributions. Visibility and transparency can be improved by posting comments and actions on a shared board or by email; or through other mechanisms such as daily huddles (page 37), debriefs (page 37), meetings (page 20) or trying out the 25 Gets You 10 activity (page 59).



JUST CULTURE

In a just culture people aren't blamed for mistakes that were caused by our care processes or system. We learn from these events and work to change the system to prevent the same event from happening again. An organization must address the human, environmental, and system factors that contribute to creating a culture of safety.⁸

1. Human and environmental factors: It is important to address both the knowledge and performance requirements that contribute to a culture of patient safety, including how incidents are followed up on and how we proactively prevent them from occurring.
2. System factors: These factors come from both inside and outside the organization and can occur at many different levels of care. Being aware of the connectivity of systems and how they influence each other is crucial to inform actions to improve patient safety.

To create a just culture, we respond to adverse events and near misses respectfully and appropriately. Essentially it is about building trust. Small displays of respect and appropriate responses to reported events build up over time and create trust.





WORKING CONDITIONS

The quality of a work environment is improved with the training of new and current providers, supervision of trainees, appropriate staffing, and reasonable workload. The degree to which people feel they have the information they need to do their job or information required to provide patient care is also a factor in working conditions.

Two initial ways to improve working conditions are to increase the availability of information and address the training and supervision of new and existing team members. Involving the whole team in identifying improvements is beneficial as managers and point of care providers often have different day-to-day experiences.



TRUST

Trust is an essential element of teamwork and open communication. In a trusting and safe environment, team members can admit their mistakes and openly discuss issues without fear of negative consequences. Interpersonal trust among team members facilitates cooperation, reduces the need to monitor one another's behaviour, and supports the belief that other members of the team won't take advantage of them.⁹

Individually, the following actions can help build trustworthiness:

Integrity	Integrity is built through both honesty and truthfulness
Competence	Competence is demonstrated by both technical and interpersonal skills
Consistency	Consistency is fostered by demonstrating reliability, predictability and good judgment in handling situations
Loyalty	Loyalty is related to one's willingness to protect and stand up for another person
Openness	Openness is made visible by one's willingness to share ideas and information freely ¹⁰

When working to foster a healthy culture, trust is a foundational element that needs to be cultivated through these actions.



TRANSPARENCY

Transparency is sharing information openly and in a timely manner at all levels of the organization. The availability of information at the point of care is important because it has a wide-reaching impact on culture. Having the information required makes it easier for care providers to do their work, and demonstrates that management is supportive. It also demonstrates that care providers are valued members of the team whose opinions matter.

Transparency is a cornerstone of both quality and accountability. Improving transparency involves an initial step of bravery: sharing information that would not usually be shared under the current culture. This doesn't mean sharing

something private or confidential; rather, relevant information that we have but simply don't think about sharing. This is a task for leadership.

It is okay to start small, and the information shared doesn't have to be perfect. What's important is how people react to this initial gesture of transparency. Work with formal and informal leaders beforehand to ensure they will support the change. If we want the transparent sharing of information to be normal, we need to react like this is normal. When we improve transparency we are getting accustomed to a "new normal" or acting our way into a new way of being.



TEAMWORK & COMMUNICATION

High quality teamwork, collaboration, communication, and conflict resolution lead to a stronger culture. Poor teamwork often occurs when there are interpersonal problems amongst members of a team.⁶ When teamwork is low, care providers feel that their coworkers are not co-operative, that their voices are not heard and that their efforts are not supported.

Patterns of teamwork are learned and often build up over time. When working to address this, the place to start is usually a "pressure point." Is there an aspect of teamwork that is visibly strained, or a procedure or process that is clearly affected by poor teamwork? Start there! Addressing the current area of frustration can really help others see the value of making a change.





SAFETY CLIMATE

Safety climate is the perceived level of commitment to, and focus upon, patient safety within a work area. Safety climate involves the ability to report safety concerns, as well as to talk about and learn from adverse events. When people indicate that they don't believe there is a good safety climate, they are telling us that they don't see a real dedication to safety. A low safety climate is related to both caregiver safety (e.g., needle-stick injuries, back injuries) and patient safety (e.g., pressure ulcers, infections).

When making changes, it is important to keep the lines of feedback and communication open. Let everyone know it is important to bring potential safety concerns and adverse events to the attention of leaders. Whatever you do to improve the ability of staff to provide input, being accountable and following up or taking action on that input is just as important, if not more important!



CULTURAL SAFETY

“Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.”¹¹ Tied to it is the concept of cultural humility. Cultural humility involves “humbly acknowledging oneself as a learner when it comes to understanding another’s experience. It is a process of self-reflection to understand personal and systemic biases to develop and maintain respectful processes and relationships based on mutual trust.”¹¹ By fostering environments that ensure cultural safety and humility, we can foster a more responsive and safe health care system.

QUESTIONS TO CONSIDER BEFORE STARTING

Before you can begin to know where changes in culture need to take place, it's important to reflect on where you are starting. These questions can help inform your next steps:

- What areas present the biggest opportunity for improvement?
- Where can you have early success that will help guide the work?
- Do you have formal leadership support for improving your team's culture?
- Do you have informal leadership support for improving your team's culture?
- Are you encouraged to report issues related to patient safety?
- Do you feel safe speaking up if you see or hear something that concerns you?
- Is it easy to ask questions if there is something you don't understand?
- How is information shared in your work area? Is it posted? Introduced in staff meetings? Or told to a few people who pass it on?

continued...

- How do people respond to near-misses and errors in your work area?
- Do you discuss past events and work to prevent the same thing from happening again?
- How does your team manage disagreement? Do you work together to solve problems?
- What do you do to welcome new team members?
- When you and your team have had a challenging but rewarding day, how do you celebrate or acknowledge a job well done?
- What helps you to do your best work?
- How do things like stress and workload affect your work? Do others share the workload and help each other out?

If the answers to these questions suggest that you have some work to do, that's ok. It is pretty rare to find a team that has no areas for improvement! This toolbox is laid out as a series of steps to help you on your culture change journey.

So, where to start? If you don't have formal or informal leader support for the work, you might want to start there – just begin to socialize the idea and get people thinking about culture! Step one is the place for you!

If you have solid support for starting to work on things, consider step two. What foundational elements of a healthy culture need some work? We've provided a road map to help you on your journey to shift culture!

READY, SET, GO!

When you think your team is ready to embark on culture change, follow the steps in this toolbox to help you make lasting change. Take it one step at a time and allow adequate time for each step.



1

ENGAGING PEOPLE *(ENGAGE, ENGAGE, ENGAGE!)*

At the beginning of any culture change, we want to talk about culture like a broken record. If we don't engage people from the beginning, it is very hard to continue the steps that follow. It is important at this stage in the process to identify champions — those individuals who are the informal leaders for the work.

Explaining the purpose of culture change is no small task. The link between culture and clinical outcomes is a relatively new idea to many people in health care. On top of this, the complexity of the concepts makes them hard to communicate in a simple manner. It helps to have an “Elevator Speech,” which is a 30-second explanation of what you seek to achieve and why others would want to join you. The following elevator speech script provides an example of how to spread the word. No email, meeting presentation, or poster is a substitute for a one-on-one or in-person conversation.

**IF WE DON'T ENGAGE PEOPLE
FROM THE BEGINNING, IT IS
VERY HARD TO CONTINUE
THE STEPS THAT FOLLOW.**

Sample Elevator Speech:

“We have an opportunity to improve teamwork and communication in our unit. <<insert a concrete example of culture such as “Learning from our near-misses and adverse events.”>>

Evidence shows that workplace culture is correlated with patient outcomes and rates of adverse events. If we can improve culture, we can improve patient outcomes and decrease adverse events.

This is important because <<insert recent event or common concern at your site>>.

You can help set the tone for culture change by being an active participant. Others look up to you and if they see you participating, they will participate too. I would love you to join us in coming up with ways we can make this change a success within our team.”

Think about which terms will resonate with your colleagues when talking about culture:

The way we work together

The way we do things around here

Workplace culture

Teamwork and communication

How we provide care together

In addition to talking about culture, we want to have a two-way conversation and truly engage others as partners in our process of change. Does culture matter to our colleagues? What would encourage them to participate in culture change?

If your organization is in the earlier stage of readiness, engagement can occur on a smaller scale. You might just identify those who are likely to be open to these ideas and work with them to plan the next steps.

2

SETTING FOUNDATIONS

Once you've engaged your team in talking about culture, it's important to ensure that it has a strong foundation from which to start. The following processes are excellent ways to build a solid foundation for culture within your team or organization.

Vision Statement and Values

A vision statement provides a roadmap for the team to aspire to. It describes the overall purpose of the team and what it is striving every day to achieve.

Values are our principles or standards for behaviour and what we hold most important. Every team and organization has values, even if they are not explicitly said. When a group articulates or writes down their values and vision, it helps them work toward the same goal, so it can be a powerful teamwork tool. Doing this exercise collectively can be a boost to job satisfaction as it helps people feel their input is heard and connects them to their purpose at work. Excluding people from the process can have the opposite effect!

Roles and Responsibilities

Ensuring that everyone on the team has a clear understanding of their roles and responsibilities is fundamental to creating a positive culture. Conflict can arise when these factors are unclear. Try having each of your team members share their own description of their roles and responsibilities. Doing this with other team members present helps provide clarity for the team. You may identify opportunities for improvement related to role and responsibility clarity by going through this process.

Training of Current Team Members

Having the skills to perform a task is an important contributor to safety. Current team members may feel that they need more training in certain areas. If possible, address this in small steps. You might review a technique or skill every three months. For example, you might train everyone on the use of one particular piece of equipment such as an IV pump over the next three months or offer a refresher course on administering the flu vaccination during flu season.

Ask current team members what they would like to learn. Use existing resources (such as a nurse educator, human resource advisor or organizational development consultant) to deliver the training. If you uncover consistent gaps in skills, look deeper at possible system factors. Is this something we can work on when onboarding new staff? Is this feedback to give to those training students? If resources or travel are restricted, is there an option for virtual learning?

Supervision and Training of New Team Members

When new team members come aboard, this is an important time to orient them to the team. Think about how you will orient new staff and what you want them to learn about the culture on your team. For ideas, ask both new and long-standing team members for what they see as gaps in training and supervision. Ask if there are better ways that new staff could be trained and supervised.

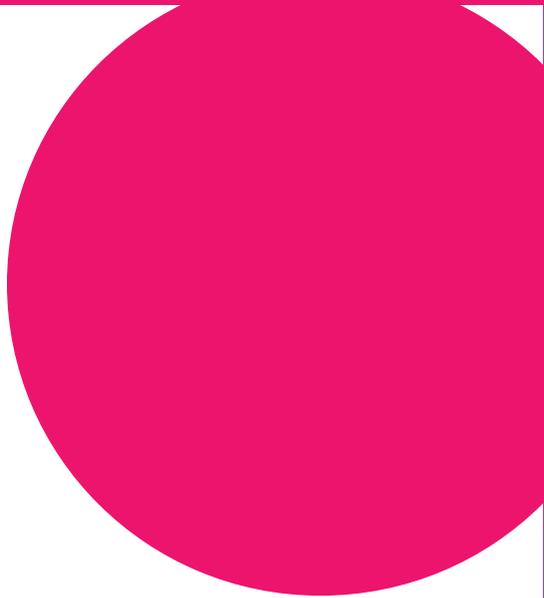


Limit Interruptions

If we reduce the number of interruptions we experience during our work day, we reduce the potential for miscommunication and errors. The first step is to assess work flow, so we're looking at what we actually do rather than what we think we do. You can do this using Process Mapping (see page 32). Once you have identified the given steps in a process, look at which can be eliminated or where waste exists.

Here are some ideas to get you thinking about opportunities to remove interruptions and “waste”:

- Are we doing something that isn't being used or isn't adding value?
Something unnecessary?
- Are we duplicating?
- Do we produce more items than we need?
- Do we touch the same thing many times throughout a process?
- Could we reduce the number of people involved?
- Are there any steps in our process that we can move closer together?
- Are team members' skills used to their full potential?
- Do we need to increase access to information?
- Is there a bottleneck?



Interdisciplinary Team Meetings

With busy schedules and different responsibilities, it can be hard to get all team members in the same place at the same time. Interdisciplinary team meetings provide a forum for all team members to develop a shared understanding of their work. They help to share information and perspectives.

To start, talk to everyone about the idea of having team meetings. Putting team meetings into place without warning may make them seem top down. As challenging as it may be, try to find a time that works for everyone. Develop an agenda or structure for the meeting and think about strategies to ensure that everyone will have a chance to speak up and provide input.

Documentation

Communication occurs in person and in writing. Revising documents can greatly improve communication overall. Walk through your core documents as an interdisciplinary team. What does each field refer to? What does each team member need to know from each section of the form? How is each section interpreted by each team member? Is there information that you are collecting that you don't use? Or, is there information that you need that you don't collect? Think about how documentation is related to shift changes or patient transfers. Test a new version of a document before making it standard practice.



Handoffs and Shift Changes

Any time there is a transfer in clinical accountability, such as shift changes, patient transfers or even the transfer of care from one care provider to another, it is important to give extra attention to communication. A simplified, generic process for information exchange goes a long way. The most powerful questions to ask during these exchanges are anticipatory, or thinking about what might happen in the future. Here are some ideas to try:

Create a structure to follow such as SBAR or IDRAW (see page 51).¹²

Create a checklist of points that must be discussed during handoffs. A checklist doesn't have to cover every detail; it focuses on the main points to ensure they are not forgotten.

Edit documentation to improve handoffs.

Introduce a safety report during shift changes or at the start of a clinic day. "Did you observe anything during your shift that is a safety concern?" or "Are there any patients visiting the clinic today that we have particular concerns about?"

Information shared during handovers or transfers can also be collected as it provides useful clues about ongoing safety concerns and systemic problems.

1. Start by identifying one team member or a small group who is willing to help improve communication about patient status at handover or shift change.

2. Review the current practice. What is key handover information that people sometimes forget to share? What information is often missing? Focus on finding out what is actually happening, rather than what you think is happening.

3. Brainstorm together as a team and identify what type of information is relevant to share during the handoff.

4. Develop a mechanism for submitting the information. Is it written down somewhere? Is it given verbally? Is it reviewed immediately or at the end of each day? How will those who submitted input receive feedback or follow-up? Is it anonymous or not?

5. Try the new process one day with a small group. Use what you learn during this test to adjust the process for next time. Repeat until the process is working for the small group before expanding further.

6. Increase the use of this formal handoff procedure by incorporating additional team members. Continue to adjust the process as needed.

7. Take action or follow up on any input given during handoffs or safety reports. This encourages the activity to continue and increases the quality. If we know our input will go somewhere, we will take the time to give valuable feedback.

8. If formal handoffs or safety reports are being performed regularly at a clinic, facility, or system level, look for patterns in information collected.

Navigating Conflict

Health care is often described as a stressful and complex environment to work in. There are many different professionals we encounter on a regular basis such as physicians, nurses, allied health and other staff, not to mention daily interactions with our patients, residents and families.

Conflict in health care may arise from personality differences, stress, disagreements over a patient's care plan, or competition for resources. While some healthy conflict can have positive outcomes by resulting in better solutions, unhealthy conflict can have a negative effect on productivity, morale and patient care.¹²

We do know that conflict often arises from ineffective communication leading to disruptive behaviours that have a direct effect on our own well-being and that of our patients. This type of conflict must be effectively managed and corrected before it escalates. We know that resolving conflicts and complaints in a timely fashion is important. It is essential that teams:

Address their differences in a timely, open and honest manner;

Attempt to resolve issues at the staffing level at which they occur; and

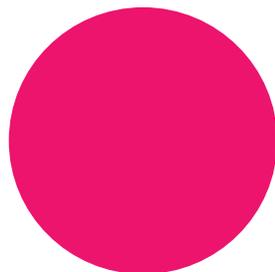
Engage third-party help (such as organizational development or human resources) only if the above steps haven't worked and it is decided that extra help is needed to resolve the issue.

Communication is at the heart of both conflict and resolution and so, by taking steps to improve our communication skills, we can improve our workplace culture.¹³⁻¹⁶ One of the ways to improve our communication skills is by examining how we listen.

Active listening means deliberately concentrating on what is being said rather than just passively hearing the message of the speaker. It is often said “the biggest communication problem is we do not listen to understand. We listen to respond.” If we don't deeply and actively listen, we can miss important meaning in conversation.

Why is active listening important?

Active listening is when you employ body language and other signs, such as verbal acknowledgement, to indicate that you are listening. Active listening is important because it establishes a connection between the speaker and the listener by signalling that you are interested and attentive. This is crucial to ensure that messages are being related properly and completely.



Deep Listening: Levels of Listening 101

Deep listening and the 'levels of listening' framework can be a useful to hold in your mind as you listen to someone, whether in a conversation with someone you are supporting or caring for, with a colleague, or even with loved ones at home.

The levels of listening are aimed at supporting us to think more deeply about how well we listen to one another, and then to listen in new and creative ways that foster meaningful, purposeful relationships between human beings - relationships that are founded on the things that really matter.¹⁷

Listening Level	Description	Place of Attention
Listening 1: Downloading	Perceiving based on your habitual ways of seeing and thinking	Habit
Listening 2: Object-Focused or Factual	Focusing on what differs from what you already know	Open mind
Listening 3: Empathic Listening	Connecting with another person and seeing through their eyes	Open heart
Listening 4: Generative Listening	Connecting to the highest future possibility that wants to emerge	Open will

To help shift your listening, take four minutes at the end of each day to reflect on your conversations and consider what percentage of time you spend on each level of listening. You can improve your listening skills by practicing and reflecting on how you listen to others. As you work to develop your listening skills, consider all levels and try to explore each when listening. Listen to what you know, what surprises you, what makes you empathize, and the deeper possibility that emerges.



**TRY THIS
ACTIVITY TO
PRACTICE
YOUR
LISTENING
SKILLS.**

JUST LISTEN

1. In advance of the activity, prepare enough index cards for each team of two to have its own set of eight cards. Each card will have a different discussion topic listed on it (e.g., the role of culture in health care, trust in our work, patient safety, etc.).
2. Ask everyone present to pair off.
3. Provide each pair with its own set of eight index cards.
4. One partner blindly chooses a card and then speaks for three minutes on how they think and feel about that topic. Their partner cannot speak during this time – their primary goal is to listen.
5. After three minutes, the listener has one minute to recap what their partner said. They cannot debate, agree, or disagree – only summarize.
6. Next, the roles switch and teams begin the process again.

INVITE PARTICIPANTS TO DEBRIEF:

How did speakers feel about their partners' abilities to listen with an open mind?

Did their partners' body language communicate how they felt about what was being said?

How did listeners feel about not being able to speak their own views on the topic? How well were they able to keep an open mind? How well did they listen?

How well did the listening partners summarize the speakers' opinions? Did they get better as the exercise progressed?

How can we use the lessons from this activity in our day to day work?

This activity is part of our online resource ATTIC, a set of interactive activities that can help foster teamwork, develop communication skills, enable creative thinking and innovation, and explore systems. Check out more at: attic.bcpsqc.ca



FOR CONSIDERATION IN THIS PROCESS...

Engaging patients can be a powerful way to help change culture

As health care providers, patient and family engagement is a critical part of patient- and family-centred care. Whether it's at the bedside or systems level, the importance of integrating meaningful engagement is illustrated through the positive outcomes it creates for both providers and patients. Having a patient involved in the cultural changes you are trying to make can be extremely helpful.

When planning patient and public engagement at a system level, BC uses the Spectrum of Public Participation (iap2canada.ca) to guide the development and expectations of both the health care partners and patients for meaningful engagement.

INFORM



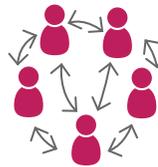
CONSULT



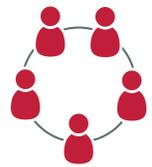
INVOLVE



COLLABORATE



EMPOWER



Examples below are interventions that include patient and public engagement at a system level, and that can ultimately impact the point of care.

Patients watch an advertisement online about washing hands	Inform
Patients attend a tour of a new community health centre and fill in a comment card on the new facility	Inform/Consult
Patients complete a survey on diabetes services in BC	Consult
Patients participate in a full-day table round discussion with diverse stakeholders on end-of-life care	Consult/Involve
Patients participate in an ongoing working group around home-support services in rural communities	Involve/Collaborate
Patients are invited to join an advisory committee on improving surgical waitlist times and experiences	Collaborate

When it comes to quality improvement, patient safety and health system redesign, both patients and health care partners bring key pieces of the puzzle to the table. A positive safety culture embraces patients as more than passive recipients of care, and instead as partners.

To encourage and support this way of thinking about and working with patients, we provide support through comprehensive tools, resources and coaching to help integrate patient and public engagement into your projects. We also support the Patient Voices Network (PVN) through facilitating connections between health care organizations and patient volunteers who want to share their experiences to help with improvements. For more information or to have a patient work with you on a culture change activity, visit www.PatientVoicesBC.ca.



3

ASSESSING THE CURRENT STATE

We assess our current culture to figure out what aspects are going well and where we can improve. Maybe our teamwork is great, but we all have a high workload and experience stress.

Assessment helps make culture tangible and concrete. Evidence of local culture is a powerful driver for change. We can assess culture through surveys, interviews, observation or coaching.

Our assessment tells us where to focus. It identifies what we are already doing well and what we need to work on. This can help inform our next steps.

Assessing culture needs to be participatory. We can actually harm our culture by asking for input without sharing the results or intending to do anything about it.

ASSESS

There are many tools that can be used to assess your team's culture.

Culture Survey

There are many survey instruments available to help you assess culture. Which instrument you choose is not that critical as most tools measure similar concepts and the findings are indicative of areas that teams can start working. The Accreditation Canada Modified Stanford Instrument (MSI), Safety Attitudes Questionnaire (SAQ), and Agency for Healthcare Research & Quality (AHRQ) surveys are usually preferred as they are validated instruments for measuring culture.

How the survey is administered is just as important as the survey itself. Whichever survey you decide to use, it should be administered at a unit level and achieve a response rate of at least 60% in each unit.¹⁸ A unit is defined by the people that work there, not by the organizational structure. Ask people who they feel are on the same team and to draw boundaries to define units.

A major culture survey is typically performed every 12 to 24 months. However, a “taking the pulse” survey with a handful of questions can be performed more easily and regularly.

A survey asks the opinions of everyone in the work area, which means it is subjective. It also has the advantage of being “owned” by those who fill it out. There is no outside messenger; the results are from the providers themselves. The quantitative results can easily be turned into graphs.



Observation

Observation can provide an objective way to gain insights into the team and its communication patterns. Sometimes, however, it can be daunting for both the observer and the observee. The observers should be clear about what is being observed and reassure the person being observed that he or she are there to learn more about their work and not to make a judgement on their performance.

Observers can use a framework or guide that clearly identifies the behaviours being observed, such as the Communication and Teamwork Skills (CATS) Assessment Instrument¹⁹ or the Oxford NOTECHS II.²⁰ The later is primarily used in a surgical environment.

When observing people at work, always be respectful and transparent about why you are there.

One of the risks of observation is that people may change their behaviour when being observed. This is called the Hawthorne effect.²¹ Observation works best when the improvement culture is already somewhat positive or when trust in the culture already exists.

Incident Analysis

Adverse events and near-misses are a rich source of information. They can help identify the aspects of culture that are sore spots in the way we work together. There are many tools and frameworks for incident analysis or adverse event review. Any of them will work. We just want to find the major patterns in past events. This can be very effective to understand all the contributing factors that result in a problem.

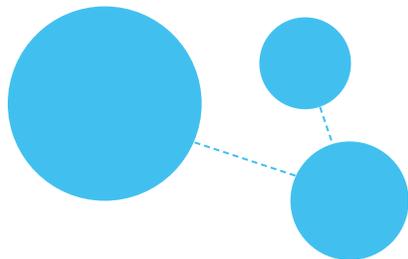
Interviews

Semi-structured interviews with all team members, or a representative sample, can provide insight as to the components of culture that need improvement. Think about who will conduct the interviews; often an outsider is more effective at getting people to speak freely. If the reliability of the data will be an issue for some members of the team, take care when defining the interview structure and selecting the person to conduct them.

PROCESS MAPPING

Process mapping is also an important tool that can be leveraged to better understand how your team is working. Process mapping is about understanding what you actually do – rather than what you think you do.

Process maps are created through group discussions that include everyone involved in performing the process. Having a map can show you where there are opportunities to improve the process by removing interruptions or waste. An additional benefit is that process mapping provides an opportunity for all team members to come together and share their perspectives on the work and supporting process. Coming together for this exercise can be an important team development tool in and of itself.



1. Define the process. Is it the path a patient takes through getting a referral to home and community care and then being seen at home for their first assessment? Is it the work of one nurse? Is it the work of the intake nurse and the home care nurse? What about the allied health team members? Where does it start and stop?
2. Get everyone involved in executing the process in one room. If the group is large, it is good to have a facilitator. If you are mapping the workflow of a large work area, it might make sense to gather a smaller group that is representative of everyone working there.
3. List all the steps in the process, and then put them in sequence. Listing all the steps on post-it notes is useful. Process maps are usually large; you can make them on a chart or brown paper.
4. Draw the flow between steps using arrows and other symbols.



WE ASSESS OUR CURRENT CULTURE TO FIGURE OUT WHAT ASPECTS ARE GOING WELL AND WHERE WE CAN IMPROVE.

How do we select the best assessment tool for our work area?

There are multiple ways, as described above, to assess culture in your area. Consider these questions before picking a methodology and tool.

What resources will we need?

Do we have the expertise required?

Will team members participate in this method?

Do we want a few ideas of where to start or do we want robust data?

Do we have any measures that can indicate how we are performing?

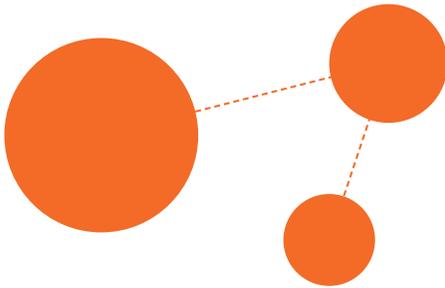
Culture change is an ongoing process. If you have picked a tool but you don't think you gathered enough information or the right information, you can always measure again using different tools. Or choose two methodologies, such as observations and interviews, so you are not just limited to one type of culture assessment.

Before we jump to solutions, it is good practice to fully understand the problem first!

4

IDENTIFYING AND ANALYZING OPPORTUNITIES FOR IMPROVEMENT

Once you have assessed your culture, it is time to analyze the results and discuss what improvements could be made. This is a critically important step, as you want to ensure that your team remains engaged and recognizes that their input has been heard and valued.



Sort Through the Data

Spend some time sorting through the data. Surveys, interviews, or observations have likely yielded quite a lot of data. If you are going to share the information in a team meeting, it is best to spend some time creating a succinct summary of the findings. Identify the major themes and design the presentation around them.

Consider the Audience

Doing a culture assessment is not about assigning blame or making people feel bad. It is about learning where there are opportunities for improvement. Consider who will be present when you deliver the findings? Will it be at a team meeting? How can you ensure that casual workers who are not present receive the findings as well? How can you frame the results in a positive light, with better patient care at the centre of discussion?

All levels of leadership should be briefed on the results of the assessment. Making changes to culture can have a big impact on staff so leadership needs to be aware of the results.



Presenting the Results and Making a Plan

Think about how you can present the results in a way that provides opportunities for team members to participate. Allow ample time for discussion. Consider how you prioritize which area to work on first. Will you use a dot voting system, where everyone places a dot beside the improvement opportunity they want to work on? Or will you choose the area that had the most negative result?

Allow your presentation to be a time to have your team think critically about the results and come up with an action plan together. Talk about the next steps and when they will happen. Ensure that the team knows what will be expected of them and how they can become involved.

What is dot voting?

Dot voting is a participatory activity that can help rank and choose priorities. For example, if your team has many ideas for where to begin your culture change work, give each person one or two sticky dots. Have each person place a dot beside the idea(s) they feel is most important. Count up the dots at the end and see which idea is deemed to be the most important to start working on and begin your work there.

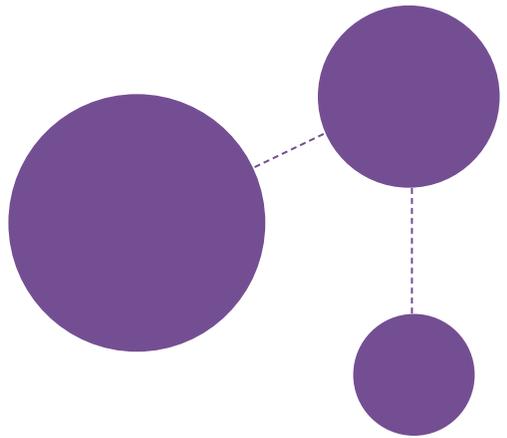
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CHOOSING TOOLS TO IMPROVE CULTURE

This section describes tools that can be used to improve culture and some techniques for generating your own ideas for change. These are just suggestions. So if you have other ideas, give them a try.

Next to each tool or process change is a symbol of the component(s) of culture that it affects most. Since the components of culture are interconnected, any change will have ripple effects and possibly improve other components — sometimes in unexpected ways. Choose an approach that feels like a good fit for your work area and has support from your colleagues.

Once you have chosen some tools to try, go on to the next section for some tips on testing and applying them.



Briefs and Huddles



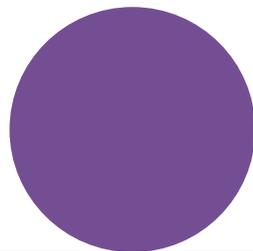
Improves: TEAMWORK & COMMUNICATION, PSYCHOLOGICAL SAFETY, ORGANIZATIONAL FAIRNESS, TRUST

Briefs and huddles are short, scheduled meetings that are typically effective for large teams working together. They are commonly used before the start of a procedure or the working day, and can be scheduled or ad hoc.

During the huddle, share the plan of action and review the major pieces of information. Verbalizing the patients' treatment plans and collaborating on patient care decisions in a structured way can improve patient safety and improve the quality of communication between team members.²²

Continuous changes to the structure of the conversation may be necessary.

1. Think about which procedure or care team would benefit from a huddle. Identify people who need to be present.
2. Develop a structure for the conversation.
 - Will you use a checklist or a set of key questions?
 - Will you use SBAR (Situation Background Assessment Recommendation), a tool described on page 51?
3. Think about practicalities.
 - Who will host the conversation?
 - How long will it be?
 - What should be discussed?
 - Is it relevant and meaningful for everyone who attends?
4. Think about the behaviours and attitudes necessary to ensure everyone is able to speak up. Huddles are a great time to ask for feedback from each team member and demonstrate that input is heard by sharing updates and actions taken.



Call-outs

Improves: TEAMWORK & COMMUNICATION, SAFETY CLIMATE, PSYCHOLOGICAL SAFETY

A call-out is when someone vocalizes or shouts out an important piece of information. These are often used during emergency situations but can be useful at other times too. For example, a nurse might call out what dose of medication she is giving to a patient. Pieces of information that all team members need to know are good topics for call-outs.

Critical Language

Improves: TEAMWORK & COMMUNICATION, SAFETY CLIMATE, PSYCHOLOGICAL SAFETY

Critical language refers to an agreed upon phrase that can be used to “stop the line” or halt activity if someone feels safety is a concern. For example, the phrase “I need clarity” can be used as critical language in a scenario such as this one:

“Dr. Smith -- I need clarity here. You ordered Tazocin for Ms. Jones, but her chart shows she has a penicillin allergy.”

1. Work with everyone in your work area to define a phrase that works for you. What will your critical language phrase be?
2. Fine tune the technique by testing it with a small group willing to help you. Practice by doing role plays or simulations. Ensure the simulation includes both the use of the critical language and the appropriate reaction (stopping the current activity).
3. Spread the technique to other staff, ensuring that it covers people working during all shifts and part-time staff. Practice by doing role plays or simulations.
4. Maintain its use by having respected and influential team members lead by example.



Closed-Loop Communication



Improves: TEAMWORK & COMMUNICATION, SAFETY CLIMATE, PSYCHOLOGICAL SAFETY

When we communicate with others, we cannot know that they heard the message that we intended to convey — unless they tell us what they heard. This is the idea behind closed-loop communication; you want to make sure the message was received as you intended it to be. Below is an example of closed-loop communication. In the example, the details are repeated in the response.

Community Nurse:	“Dr Ward, I’m calling about a Critical Action Value lab result for resident Mr. Patel, MRN12345. His INR is 6.0 today.”
Doctor:	“Ok – Mr. Patel MRN12345 has an INR of 6.0. Please hold warfarin for 2 days then reduce dose to 2mg daily and repeat blood work on Thursday.”

1. Define when call-outs and closed-loop communication are expected to be used.
2. Start small. For example, you might start closed-loop communication when administering a particular medication and then expand the practice to other medications or other procedures.
3. Fine tune the technique by testing it with a small group willing to help you. Practice by doing role plays or simulations.
4. Spread the technique to other staff, making sure that it covers people working during all shifts and part-time staff. Practice by doing role plays or simulations (see page 54 for a description).
5. Spread the use of the technique to other procedures, patient populations, etc.
6. Maintain its use by having respected and influential team members lead by example.

“CUS” Words



Improves: SAFETY CLIMATE, PSYCHOLOGICAL SAFETY, TEAMWORK AND COMMUNICATION

“CUS” is an acronym that stands for the following:

I'm concerned...

I'm uncomfortable... This is unsafe...

I'm scared... This is a safety issue... STOP.

This set of words is effective at increasing the level of concern about a safety issue without generating too much confrontation. Using CUS words can make it easier to speak up about a safety concern because it gives us something easy and automatic to say. All members of a team need to know that these words are meant to imply a safety concern.

1. Choose which words will be your CUS words. Will you use “uncomfortable,” “unsafe,” or both?
2. Make it common knowledge that these words are used to bring up safety concerns.
3. Practice! Try simulating conversations using CUS words. When faced with a tough situation, we are more likely to display desired behaviour if it has been practiced beforehand. Try having a third team member observe and coach as others practice using CUS. Alternate roles in the script to practice saying CUS words, and to practice hearing them.
4. Find key team members to lead by example.

“CUS” Words continued...



Here is an example using CUS words

Scenario: [Adult daughter lives with her elderly mother and is visited by the community nurse and occupational therapist]

Community Nurse:	"I'm concerned about your mother. Is her breathing getting worse? How are you doing looking after her?"
Daughter:	"It's getting tougher doing this all by myself; it's just me looking after her."
Community Nurse:	"It sounds like this is becoming more of a problem and I'm getting uncomfortable with having this all on you at home."
Daughter:	"I'm just about at the end of my rope, I don't think that I can look after her anymore."
Occupational Therapist:	"I think that we will have to stop and get you some help caring for her."
Daughter:	"I found her on the floor this morning and hurt my back getting her back into bed by myself."
Occupational Therapist:	"This is becoming a safety issue for both you and your mom. We can look into home care to help with her medication and personal care to give you a break while we create a new plan of care that relieves some of the burden from you."

Questions for reflection

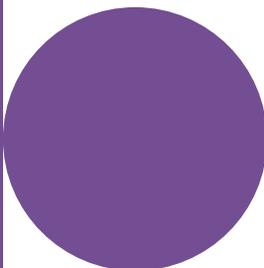
1. How does it feel to practice using CUS?
2. Could this be helpful in your work area?
3. How would you have handled this situation without CUS?
4. If you saw this happen in your work area while you were observing, how would you have coached those involved afterward?

Feedback: Asking For and Receiving Feedback

Improves: PSYCHOLOGICAL SAFETY, ORGANIZATIONAL FAIRNESS, TRUST, TRANSPARENCY

Our ability to speak up depends on the situation, our comfort, and also on our personalities. A great technique to increase input from all team members is to explicitly ask for feedback from them using their names. Ask, “What do you think, Barbara?” then say thank you!

Respecting and acting on the feedback is just as important as asking for it. This tool can improve the sense that input is valued and promote coordination between team members. It is very helpful when you want to break a pattern of silence or when some members of your team are naturally reluctant. To implement this tool, think about the appropriate person to be asking for feedback. Is it a manager, a nurse or everyone on the team?



Feedback at the Point of Care



Improves: ORGANIZATIONAL FAIRNESS, SAFETY CLIMATE, TEAMWORK AND COMMUNICATION, TRANSPARENCY

The goal here is to increase communication at the point of care and to take actions to show that the input provided was received. There are a number of ways to give feedback to staff, such as regular safety meetings, Leadership Walkarounds (see page 44), poster boards and personal follow-up. Ask your team members how best to communicate, discuss and decide as a group. Here are some tips:

1. Ensure that the feedback reaches all staff members, including those who work on alternate shifts, on weekends or intermittently.
2. Develop a newsletter for communicating safety information, or add a page or column to an existing newsletter. Make sure some messages come directly from senior leaders.
3. Recognize and thank staff members in front of their peers for their suggestions.
4. Give feedback about each suggestion even if you can't act on it. Make sure the staff member who made the suggestion knows it was investigated and explain why you could not take action.
5. Make responses timely - failure to provide prompt feedback will make staff members think you don't listen or take action.

Leadership Walkarounds



Improves: TRANSPARENCY, LEADERSHIP, WORKING CONDITIONS, TRUST, ORGANIZATIONAL FAIRNESS

Leadership walkarounds connect senior leaders with point-of-care staff, allow senior leaders to demonstrate their commitment to the work, and provide an opportunity for point-of-care staff to share their concerns regarding patient safety and satisfaction.²³ Visible leadership also provides an opportunity to demonstrate a commitment to safety and identify opportunities to improve it. Just as important, it establishes lines of communication between point-of-care staff and leadership about patient safety issues.²⁴⁻²⁵

1. Decide whether or not you will announce when a Leadership Walkaround will occur. Ensure that all staff know that information discussed in a walkaround is confidential.
2. Decide which senior leader will attend and with what frequency. Will a different senior leader attend each week? Will the walkaround occur every week? Every month?
3. Encourage the senior leader to speak to at least 3-5 point-of-care staff from a particular area (unit, floor, team, etc.). These can be informal conversations. Another option is to schedule organized conversations with staff members where senior leaders can ask questions to a small group of staff.
4. The senior leader should ask questions relevant to patient safety and just culture. For example, "Have there been any incidents lately where a patient was harmed?" or "What can intervention can a senior leader make to help your work be safer for patients?"
5. Ensure there is a protocol for following up on the issues raised by staff. This demonstrates a commitment to point of care staff and increases transparency in the organization.



Learning Board



Improves: TRANSPARENCY, LEADERSHIP, WORKING CONDITIONS, TRUST, ORGANIZATIONAL FAIRNESS, SAFETY CLIMATE

A learning board is a way to show learning from past activities or improvement projects.

A learning board is typically a poster board with three sections: opportunities, actions and outcomes. The three sections are also sometimes called “opportunities”, “in progress” and “resolved.” Opportunities can be clinical, behavioural and/or operational (but categories are not necessary). Actions refer to what is done in response to the opportunities, and outcomes refer to the end results of actions taken. A learning board visibly demonstrates that action is taken in response to input from team members.

Learning boards are linked to leadership. They give leaders valuable information about what is happening on the unit or work area and they show providers that leaders will take action on their input. They work great in conjunction with Leadership Walkarounds (page 44).

- Learning boards are most powerful when any team member can freely submit an opportunity for change and all suggestions are displayed. Do we want a few ideas of where to start or do we want robust data?
- It is important that action is taken on all suggestions and to be clear about what can and can't be done. For example, publicly pledge to work on one opportunity per month.

Opportunities	Actions	Outcomes
<i>Clinical</i> We should be using clippers instead of razors to shave the incision site.	<i>Clinical</i> The team working with Dr. Robertson will test the use of clippers on Wednesday morning.	<i>Clinical</i> We are now using clippers for about half of our surgeries.
<i>Behavioural</i> We don't use each others' first names.	<i>Behavioural</i> We will introduce each other during our morning huddle, or the checklist. Dr. Wong will champion this practice.	<i>Behavioural</i> The use of first names is included in our checklist.
<i>Operational</i> Our supply cupboard needs to be organized.	<i>Operational</i> John will organize the supply cupboard next Thursday.	<i>Operational</i> The supply cupboard is now organized.

Learning from Defects



Improves: JUST CULTURE, SAFETY CLIMATE, PSYCHOLOGICAL SAFETY

When things don't go as we planned, it is important to learn from what happened in order to prevent it from happening again. Learning from defects promotes a positive safety culture and also shows that safety is something we can talk about. We ask four questions:

What happened?	Why did it happen?	What did you do to reduce risk?	How do you know risks were reduced?
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1. Start by reviewing hypothetical or old cases with the team. This allows the team to become comfortable with the process of reviewing adverse events and talking about safety.
2. Once the team is comfortable with these discussions, introduce more recent events from your own work area.
3. When comfort with this process is high, learning from defects can take place as a quick discussion in the work area as a part of the normal work process.
4. You might add symbols indicating steps where a decision is required, where certain team members are needed, where information is involved, or where documentation is completed.
5. Review the map to look for opportunities to improve the process or change patterns of teamwork.

Reporting Culture

Improves: JUST CULTURE, SAFETY CLIMATE, PSYCHOLOGICAL SAFETY, TRUST, TRANSPARENCY

A reporting culture refers to an organization where people are prepared to report their errors and near-misses. The reporting of these events is necessary if we are to learn from them and prevent similar events from happening again. In order for people to report these events, they need to feel confident that they will not be punished for doing so and that their input will be acted upon. It is critical to create a culture of psychological safety in order to allow a reporting culture to flourish.

To encourage reporting we need to:

1. Take visible action on an error or near-miss that was reported. It can be anything, even something small. Choose something manageable as a first step. Address the problem and share both the problem and solution with the group. Better yet, work together to create a solution. See the Learning from Defects activity on page 46 for more.
2. Thank the person who reported the event or situation. If appropriate, a public acknowledgement is even more powerful.
3. Repeat! We must continue this activity in order to show that it is not a one-time experiment, but rather a permanent part of how we work.

What we are really doing here is building trust. We are symbolically demonstrating that the reporting of errors and near-misses achieves a tangible result.

Reporting System for Safety Events

Improves: JUST CULTURE, TRANSPARENCY

The reporting of errors and near-misses gives us information about what is happening in our organization in regards to patient safety. Without it, we are essentially blind. How can we learn from past events or make improvements without it? A reporting system supports this activity by making the process for event reporting clear.

In British Columbia, many of the health authorities use the Patient Safety & Learning System (PSLS). We can always improve how we use PSLS locally. Do the people in your work area know how to report an event in PSLS? Is it easy to access a computer to use PSLS? Is there someone who regularly reviews the reports and acts on them? Do team members get feedback about what happened in response to reported events? Is reporting an event a non-punitive process?

To be effective, PSLS reports need to be used to support learning rather than assigning blame. Making PSLS work in your unit will give your team the infrastructure to learn from past events. For related activities, see Learning from Defects on page 46 and Reporting Culture, on page 47.



Safety Huddles or Safety Briefings



Improves: SAFETY CLIMATE, TEAMWORK AND COMMUNICATION, LEADERSHIP

Safety huddles are regularly scheduled, short meetings to talk about safety. They are an important forum where safety concerns are addressed. Having safety briefings promotes a culture of safety. The steps below for a safety huddle were adapted from the Institute for Healthcare Improvement.²⁶

1. Identify a team or small group of staff that is willing to try something new. Host a trial safety huddle one day during one shift with this group.
2. Start by explaining the purpose of the huddle: to discuss safety concerns of the past, present and future. Emphasize that it is not about blame. It is about increasing safety.
3. Think about some example issues to bring up at the first huddle. At first, it might not be clear to everyone what sort of topics they can bring up.
4. Keep it short. Five minutes is reasonable.
5. Thank everyone for their participation and be clear about next steps. Will someone follow up on the issues raised? Will there be another huddle? What changes can we make to the structure of the huddle to make it more effective?
6. Adjust the structure of the huddle using this first group, then expand to have them more often or with more staff. Aim to include all team members eventually and determine how often you would like to hold safety huddles in your work area.
7. Be transparent with follow-up. Share the outcomes of the huddle using email, meetings, posters or personal conversations. Acting on the information shared during safety huddles sends a powerful message that the safety matters.
8. Once safety huddles happen regularly, train other team members to host them so that they can take place without requiring the original facilitator.

Safety Champion

Improves: SAFETY CLIMATE, LEADERSHIP

Safety is everyone's responsibility. A safety champion is someone who has the knowledge and skills to be a resource for everyone.²⁵ Having a safety champion also symbolizes the importance of safety.

1. Anyone in your unit can be a safety champion. It's more important to choose someone who volunteers than someone who has a particular job title.
2. Give this person extra training on topics like the procedure for documenting safety issues, the science of safety (such as human factors) or quality improvement. The goal is for him/her to act as a resource for everyone else while promoting a non-punitive approach to safety.
3. Give the safety champion additional ability to act on safety concerns such as the authority to make certain types of changes to processes or to have an allotted time during meetings.
4. Present the safety champion to the other team members as their ally. Ensure that the safety champion's role is truly non-punitive, to allow him/her to act as a resource to others.

SBAR - Situation Background Assessment Recommendation



Improves: TEAMWORK & COMMUNICATION, SAFETY CLIMATE, LEADERSHIP

SBAR is a framework for communicating information, and has been adapted for use in many different health care settings. When all team members are consciously aware that they are using the same framework, communication is much easier for everyone involved. SBAR can be used in-person or over the phone and it can also be used to structure forms and meetings. SBAR has four components:²⁸

Situation	Background	Assessment	Recommendation
What is the situation at hand?	What is the relevant background information about the patient?	What is your assessment of the situation?	What do you think should be done, or what is it that you need? What is the specific solution to the problem?

1. Start by finding a few people in your area who are interested in communicating using SBAR.
2. Think about how the SBAR framework applies to your work. Do you need to create a form or edit existing documentation? Do you need a reminder near the telephone?
3. Practice using it among a few team members and make any changes to the protocol before spreading to others.
4. Spread awareness of what SBAR is and why it is being used. Is it solving recurring miscommunication? Is it being used at particular times such as phoning consulting physicians or emergency situations?

An example of SBAR

Scenario: You are working a night shift on unit A and you go into your patient Mrs. Liu's room where she says she is short of breath. You do an assessment on her and realize she may require an intervention. She had a knee replacement two days ago and has been experiencing chest pain and shortness of breath for about two hours.

You do a set of vital signs and decide you need to call the physician to discuss Mrs. Liu's status.

Situation	Nurse: "Here's the situation: Mrs. Liu is having increasing dyspnea and says she is having chest pain."
Background	Nurse: "The supporting background information is that she had a total knee replacement two days ago. She began experiencing chest pain about two hours ago. Her pulse is 120 and her blood pressure is 128 over 54. She is restless and short of breath."
Assessment	Nurse: "My assessment of the situation is that she may be having a cardiac event or a pulmonary embolism."
Recommendation	Nurse: "I recommend that you see her immediately and that we start her on O2 stat. Do you agree?"

Another structure communication tool that you can use instead of SBAR is IDRAW.



IDRAW is designed for communicating information during a handover.

I	Identify two patient identifiers and the identity of the Most Responsible Provider
D	Diagnosis and a clinical systems review including current problems
R	Recent changes and up-to-date vital signs
A	Anticipated changes in the next few hours and tasks needing attention
W	Opportunity to ask questions such as, "What else should I be worried about?"

An example of a completed IDRAW

Scenario: Mr. Lee has become a resident at your care home as of yesterday. He is recovering from a broken hip, has hypertension, and is incontinent. Your shift has come to an end and you want to update the oncoming health care team.

Identify two patient identifiers and the Most Responsible Provider	Mr. Lee, 60 years old, room 230. Most Responsible Provider: Adam Kang.
Diagnosis and clinical systems review including current problems	Currently stable. Recovering from a hip fracture. History of hypertension. Indwelling urinary catheter.
Recent changes and up-to-date vital signs	No recent changes to report. Vital signs stable at 0800, pain scale 1/10.
Anticipated changes in the next few hours and tasks needing attention	No anticipated changes. Usual catheter care, hypertension medication, and hip fracture recovery.
What else should I be worried about?	Urinary output 300 ml this shift, encourage fluids.

Simulation

Improves: PSYCHOLOGICAL SAFETY, SAFETY CLIMATE, TEAMWORK AND COMMUNICATION

Simulation-based training can have a significant effect on increasing clinical team performance by allowing teams to practice critical skills in a safe environment.²⁷⁻²⁸

By including all members of the inter-professional team in a simulation, attitudes towards teamwork can improve and new relationships can be fostered, particularly between disciplines.³¹ Whether simulations occur in situ or in a simulation centre, an additional structured debrief following the event will greatly enhance provider satisfaction.³²⁻³³

In situ simulations have the added benefit of being less costly and can be adapted to reflect a scenario that may have occurred in our own facility. When we act out a scenario, we learn and practice the behaviours we want to use if and when the situation actually occurs. The debrief helps us learn what we can do better next time. Simulation can be used to practice the use of any behaviour, such as using a communication technique or responding to an adverse event.

1. Develop a script to act out. It is more powerful if it contains an example that is a frequent occurrence in your work area. Scripts that are over the top and creative are usually successful!
2. What do you want to achieve by going through this simulation? Embed a communication technique or other tool into the script. For example, practice using the Call-out tool (page 38) when responding to adverse events.
3. Identify the people that you hope will take part.
4. Fine tune the script by trying it first with a group of people who are already interested in changing your work area's culture.
5. Use the script to train other team members. An intermediate step might be to have others watch the first group perform the simulation before practicing it themselves.



Try this ATTIC activity to practice communication. Find more activities at attic.bcpqc.ca.

TELEPHONE GAME

When we communicate with others, we cannot know if they have heard us as intended unless they tell us what they have heard. Communication strategies like closed loop communication can ensure the message was transferred as intended. Telephone is an easy way to experience the differences between one-way (open-loop) and two-way (closed-loop) communication.

INSTRUCTIONS (Group Size: 5-10 people)

First person reads the statement quietly to the next person in line

That person whispers what they heard to the next person in line, and so on

The last person shares what they heard with the group

The first person reads the original message aloud

We recommend performing at least two rounds of this exercise, first using memory only and then using the communication tool

ROUND 1:

1. Whoever is speaking delivers the message only once and cannot repeat the message
2. No one can ask questions or write anything down
3. The last person shares the message they heard aloud
4. Debrief with the group

Example Messages for Round 1

This is Mr. Jones, born March 27, 1956. He is here for a laproscopic right hemicolectomy. He has a latex allergy.

This is Mrs. Page. She is 78, lives at home alone, and has limited mobility. Her home has a lot of stairs and she is having trouble getting in and out of her bathtub.

ROUND 2:

1. Each person who hears the message repeats back what they heard
2. They may also ask one clarifying question
3. Continue with the new rules through the entire group
4. The last receiver will share the message they heard. See how it compares to the original message
5. Debrief with the group a second time

Example Messages for Round 2

Mr. Simmons, in room 410, needs blood drawn at 1100. He'll need an INR in a red cap bottle and get it to the lab on 3rd floor within 10 minutes.

Mrs. Sahota needs her flu vaccine when she comes in for her follow-up appointment at 4pm.

Debriefing questions:

1. What were the differences between Round 1 and Round 2?
2. What was the difference in the accuracy of the message conveyed?
3. Did you feel the flow of the message change depending on one-way versus two-way communication?
4. Was there a clarifying question that was helpful?
5. How can we embed closed-loop communication in our day-to-day work?

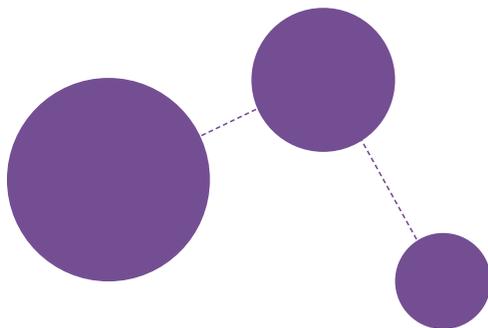


Use First Names

Improves: WORKING CONDITIONS, TEAMWORK AND COMMUNICATION, SAFETY CLIMATE, TRUST

Teams whose members call each other by their first names perform better in a critical situation than those who don't.²⁶ When people know each other's names, they are more likely to speak up about a safety concern. Institute a defined time at the beginning of the day or procedure to introduce all team members. When hierarchy exists, look for leaders in the "higher" group to model the behaviour. For example, find a physician who is willing to insist upon the use of his/her first name.

Using first names is an example of reducing Power Distance Index (PDI).³⁴ PDI is the extent to which the less powerful members of organizations accept and expect that power is distributed unequally. The higher the PDI in a culture, the less likely those in subordinate roles will question the actions or directions of individuals in authority, thereby reducing people's likelihood of speaking up.



Mitigated speech is any attempt to downplay or sugarcoat the meaning of what is being said. People use mitigated speech when they are being polite, when they're ashamed or embarrassed, or when they are being deferential to authority. Mitigated speech in deference to authority, is more common in high PDI cultures. In health care, this can be a problem as key information may not be transmitted in the most effective manner. Being open about the role that mitigated speech plays on your team is the first step towards reducing PDI and inappropriate mitigated speech. Asking for feedback and using structured communication tools, such as SBAR, to transfer information help to address mitigated speech.



Improves: TRUST, TEAMWORK AND COMMUNICATION, PSYCHOLOGICAL SAFETY, LEADERSHIP, ORGANIZATIONAL FAIRNESS

TRIZ is an acronym that stands for the Russian phrase “teoriya resheniya izobretatelskikh zadatch” which translates to “inventive theory of problem solving.” Using TRIZ helps us act out all the ways a process or a system can fail due to individual behaviours and communication. Once these are identified, the team can start working on which of those behaviours have to stop and what we can start doing better.

1. Start by asking a question. For example, “How can I ensure I do not pass any of the courses I require to upgrade my training?” How would you answer this question? It can be really fun to brainstorm these hazards in a group!
2. Once you have a list of potential pitfalls, ask if any of these things are happening right now and circle those items on your list. For example, “I am not making time to study.”
3. Finally, look at how the circled items can be turned into ideas for improvement. Is there anything we can stop doing? Should we watch out for any hazards or obstacles? For example, “Can I start setting aside one hour each weekend to study?”

Discuss this example, and then try asking a question related to your work.

25 Gets You 10

Improves: TRUST, TEAMWORK AND COMMUNICATION, WORKING CONDITIONS, TRANSPARENCY

1. Have everyone write down an idea for improvement on an index card.
2. Stand up and randomly pass the cards around the room until someone says stop.
3. Once the passing stops, pause and read the card that you have in your hand and give the idea on the card a score out of 5.
4. Write the score on the back side of the card so as not to bias the other people who will be giving the card a score.
5. Repeat this process four times until each card has 5 scores out of 5.
6. Invite the last person to receive a card to tally the scores, for a total score out of 25.
7. Ask the group if anyone has a card with an idea that received 25 points. 24 points? 23 points?
8. Read the ideas with high scores out loud. Using the wisdom of the crowd can help surface amazing ideas.

5 Whys

Improves: TRUST, TEAMWORK AND COMMUNICATION, SAFETY CLIMATE, PSYCHOLOGICAL SAFETY

The idea here is to keep asking questions that begin with “Why.” Why don’t we feel that our care team works together as a well-coordinated team? Let’s say the answer has to do with communication. Why do we feel like communication between nurses and care aides could be improved? Why does it feel like we’re speaking a different language? Why do we use different terms when we mean the same thing? Why don’t we agree on some common terms to use? The more we ask, the closer we get to underlying causes and potential change ideas.

When asking ‘Why’ questions, be considerate that they are not used in an interrogatory manner but rather used to open up the conversation to better understand all aspects of an issue causes.

TRIZ, 25 gets you 10, and 5 Whys are all types of Liberating Structures which are wonderful facilitation methods that help increase engagement in a group.

Check out liberatingstructures.com and our ATTIC activities for more ideas.



6

TEST YOUR CHANGES

Changing Culture Means Creating Space to Learn

When you start to work on changing culture, you want to ensure you know what changes you are testing and subsequently, learning from. In a learning environment, failure and mistakes are seen as opportunities to build upon. Learning is a normal part of work and it can be as simple as asking “What can we do better?” at the end of every shift or procedure.

To promote a culture of learning and improvement, create opportunities for team members to provide their ideas for improvement through regular debriefing.³⁵ As with any effort that seeks input from point-of-care providers, giving feedback or following up on what actions were taken is just as important.

How will you know if your changes are having a positive effect?

There are several models that you can use to test out your changes. Although we offer a few suggestions of models in this toolkit, we recommend choosing elements from the model that best suit your project’s unique needs.

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The Model for Improvement³⁶

Many of us are familiar with the Model for Improvement as it uses Plan-Study-Do-Act (PDSA) cycles, which are widely used in health care. In this model, there are three fundamental questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

Any effort to improve something should result in answers to these questions. For example, if your team was looking to improve psychological safety, the answers to the questions may be:

1. We are looking to improve the psychological safety of our team members.
2. We will know that an improvement has been made when our scores on the XX tool have improved by 10% by X date.
3. In order to help make this change, we will start by implementing a learning board in the staff room. Leadership will commit to responding to all comments that are left on the board. Subsequently, we may try implementing a daily huddle where adverse events or near misses will be reviewed with a mindset to learn from these events.

Using PDSA cycles, you can test, document, and assess the culture changes you are making.



Positive Deviance

Have you ever noticed someone who effortlessly does their job well? Perhaps an administrative assistant or clerk who always seems to have their unit scheduled on time? Is there a care aid who regularly voices safety concerns even when it's difficult to do so? Maybe these people are positive deviants! We're all in the same environment. We have the same resources and barriers, yet sometimes an individual has found a way to be more efficient or provide higher quality care. This person is a deviant, in a positive sense.

Most groups of people and even individuals do things differently. This variation is a goldmine for thinking of ways to improve your group's practices and culture. Studying the behaviour of positive deviants can uncover ways to change that fit with your local environment.

When using this approach, write down the behaviour of the positive deviant. Think how you can apply it to your own situation. Test and document the change and debrief with your team.

EPIQ

Confused on how to test and measure these changes? Need an epic resource to give you more guidance? Check out EPIQ!

The Engaging People in Improving Quality (EPIQ) Teaching Toolkit was designed to help those interested in quality improvement to guide improvement efforts within the context of health care. This toolkit will walk you through how you can start an improvement effort within your team.

**Visit BCPSQC.ca
to download EPIQ.**

Still unsure?

Check out the Appendix (page 65) for a complete example of how to work through the steps of changing culture.

CREATE THE CHANGE YOU WANT TO SEE

Changing culture is not always an easy path. You may encounter resistors or naysayers along your way. But don't give up! Building a strong culture for your team helps to create a happier work environment, better communication and, ultimately result in better care for patients.

Continue to consult the resources in this toolkit on your journey. Try different steps depending on where your team is at: engaging people, setting foundations, assessing the current state, identifying and analyzing opportunities for improvement, choosing tools and testing changes. Use different strategies in the tools section of the toolkit to help shift culture.

And don't forget to celebrate your wins! Recognize when steps have been accomplished. Give kudos to your team. Acknowledge the changes that have been made.

Most importantly, keep it up! Like a garden, culture needs constant attention to flourish. Find like people who are eager to foster a positive work culture and engage them in helping to maintain momentum and positivity!

“CULTURE DOES NOT CHANGE BECAUSE WE DESIRE TO CHANGE IT. CULTURE CHANGES WHEN THE ORGANIZATION IS TRANSFORMED; THE CULTURE REFLECTS THE REALITIES OF PEOPLE WORKING TOGETHER EVERY DAY.”

— Frances Hesselbein
The Key to Cultural Transformation,
Leader to Leader⁴³

Appendix

In order to help you see how all of these pieces can work together, here is a detailed example of how you can change culture. In this example, we will work on trying to improve teamwork and communication after breakdowns in these areas lead to several adverse events.

Scenario: you are a team lead. Several new team members have recently joined your team. The new team members seem shy to offer up their opinions. You are worried that adverse events or breakdowns in the care plan may result if new team members don't feel welcome or willing to communicate with the rest of the team. You decide to do something about it.

Step 1: Engaging people

You decide that your first step will be to bring up the importance of communication and trust at your next team meeting. You prepare your elevator speech and deliver it.

“I am so pleased that we have new members who have joined our team. I want this to be a team that has strong teamwork, communication and trust. We have an opportunity, with so many new members, to look at how we communicate with each other and how we can build trust within our team. Better communication and trust is correlated with fewer adverse events and a higher satisfaction at work. I would love to hear from anyone who is ready and eager to work on this within our team. My door is always open so if you have any questions that you don't want to raise now, please come talk with me.”

Step 2: Setting foundations

You consult the Setting the Foundation section of this toolkit. You identify that your team has no formal way to orient new staff to the team culture or the work. You decide to pair up new staff members with current team members for several shadow shifts, so they can have a proper orientation to the work and the team culture.

You also decide that reviewing the team's vision and values would be an important step at your next team meeting. You put it on the agenda for the next meeting and devise a participatory exercise to have everyone included in revising the vision and values of the team.

Step 3: Assessing the current state

Now that the foundation has been set, you decide that a culture survey would be the most appropriate way to determine what aspects of teamwork, communication, and trust could be improved. Although other methods such as observations or interviews could have been used to assess culture, you decide that a survey would be most appropriate as many of the new team members are shy to speak up and may not feel comfortable being observed or giving an interview.

You pick a validated tool such as the Safety Attitudes Questionnaire or Accreditation Canada's Modified Stanford Instrument³⁷ and ask your team to fill it out. You give your team two weeks to complete the survey.

Step 4: Identifying and analyzing opportunities for improvement

The culture survey results provide you with a lot of data! You take some time to analyze the data and pull out key themes from the results.

You spend some time thinking about how you want to discuss the results with your team. You brief your director on the results and ask for their input as well. Some questions to consider together include:

How will the results be presented at the team meeting?

Will your director be present when the results are shared?

How can you ensure that the results are shared in a non-judgmental way?

How will you identify the most important change to start with? Will you use a participatory approach to decide? Dot voting?

You've thought about all of these questions and present the findings at the next team meeting. Using dot voting, you asked team members to vote for the area of improvement they want to start with. They identify wanting to try improving communication within the team.



Step 5: Choosing tools

Now that a priority has been identified, you consult this toolkit to pick a tool. Together with your team, you decide a daily huddle would be a good place to start on improving communication. You discuss this decision with your team and you decide to try it for one month, doing a daily huddle every day at 8:30 am.

Step 6: Testing changes

In order to see if implementing a daily huddle is effective, you decide to use the Model for Improvement and implement Plan-Study-Do-Act (PDSA) studies. Using the guiding questions from the model, you answer the following:

1. What are we trying to accomplish?

ANSWER: We are trying to improve communication within the team.

2. How will we know that a change is an improvement?

ANSWER: We will know that a change has improved when we see a 10% increase in the results in the dimension of communication barriers/teamwork climate in the culture survey, which we will repeat in six months.

3. What changes can we make that will result in improvement?

ANSWER: We will implement a daily huddle for one month at 8:30 am every day. We will track attendance, make daily notes about each huddle, and ask for feedback at the end of each huddle on how we can make them more effective.

After one month, we will ask staff if they have found it beneficial and if they would like to continue. If they do not, we will attempt a new tool to try and improve communication.

At the end of six months, we will re-do the culture survey to see if there has been any improvement in the questions related to teamwork, communication, and trust.

Step 7: Engage, engage, engage

Culture change is ongoing. Once you've tested one tool, circle back to the beginning to continuously engage your team. Keep the communication lines open so team members feel comfortable speaking up about aspects of culture they want to see change. Culture does not change overnight; instead, it changes slowly through deliberate actions over time. You can do it!

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About the BC Patient Safety & Quality Council

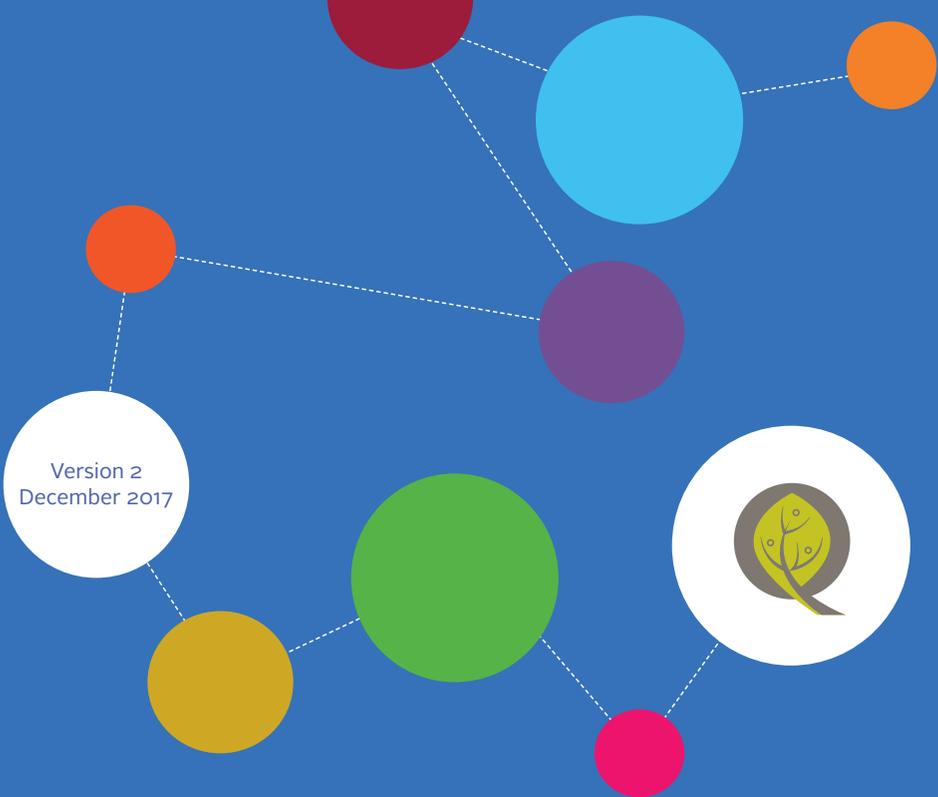
We provide system-wide leadership to efforts designed to improve the quality of health care in British Columbia. Through collaborative partnerships with health authorities, patients, and those working within the health care system, we promote and inform a provincially-coordinated, patient- and family-centred care approach to quality. We also provide advice and make recommendations to the Minister of Health.

In support of this mandate, we undertake activities that are determined through extensive consultation with our partners and stakeholders to define where we can best add value. Drawing on our resources, relationships and the diverse expertise of our staff, we are at once a leader, an advisor, a partner, a facilitator, an educator, and a supporter.

We also provide a bridge to the best knowledge in health care quality available across Canada and beyond. We seek out national and international partnerships to learn of innovation of value to BC, adapt these new ideas to meet the needs of our health care system, and work with our partners to put them in place.

Visit **BCPSQC.ca** to learn more about our programs and resources that can help you improve the culture in your workplace. This toolbox featured a couple activities from our resource ATTIC: Activities for Transforming Teams and Igniting Change – to download the full set of activities, visit **ATTIC.BCPSQC.ca**.





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