

## **Gain without Pain: Improving Patient Safety, Patient Care and Employee Satisfaction through Appreciative Inquiry**

### **Background**

Newark Beth Israel Medical Center (NBIMC), an affiliate of the Saint Barnabas Health Care System, is a 673-bed teaching hospital based in Newark, N.J. with over 80,000 Emergency Department (ED) visits per year; over 60% of patients are admitted from the ED.

### **The Patient Safety Challenge**

A landmark report released in 1999 by the Institute of Medicine (IOM) revealed that as many as 98,000 Americans die each year and one million are injured due to preventable medical errors. The IOM report and others reinforce the need for better patient safety systems. Each time a patient moves from one environment to another, there is risk that essential information regarding care will not be accurately communicated. Time constraints require nurses to share this information quickly. Safety can be jeopardized because nurses work amidst competing priorities to achieve safe, timely, effective, and efficient patient care.

Nancy Shendell-Falik, Vice President of Patient Care Services at NBIMC, and her senior staff sought an improvement process that would produce significant and rapid results for patients, the nursing staff and the hospital. In December 2004, NBIMC considered various solutions and chose to work with Michael Feinson and Bernard Mohr, Principals of Innovation Partners International. Shendell-Falik and the consultants agreed that “cultural change” would be a desired outcome but that the highest payoff would come from an approach that improved a core process and had the potential to enhance patient care in a short period of time. Shendell-Falik selected the handoff of patients from the ED to the A6 Inpatient Telemetry Unit. Redesign of this process complements the Joint Commission on Accreditation of Healthcare Organization’s (JCAHO) 2006 National Patient Safety Goals.

### **The Solution: Appreciative Inquiry - A Positive Approach to Change**

The consultants and the nurse leadership team assumed the best ideas to improve the ED to A6 handoff would come from those individuals who worked closest to the process, so their first step was to engage them in developing solutions to improve it.

The team considered the traditional approach of identifying the problem, analyzing root causes and exploring solutions. Although this approach has proven to be successful, it was not selected because of its limitations. When organizations focus on “what’s wrong” (e.g. ineffective leadership, process breakdown, miscommunication, etc.) and hold meetings with employees to resolve problems, it often leads to blaming and defensiveness. Many employees have described that after these meetings they have a heightened awareness of the problem and feel its impact in an even more negative way. As these discussions continue, employees often become discouraged and less optimistic that the problems will ever go away. Additionally, the solutions that are generated often fall within the parameters of the defined problems, rather than something that’s truly new and innovative.

IPI introduced the leadership team to an approach for organizational innovation and implementation called Appreciative Inquiry (AI). AI works by acknowledging problems and then engaging groups in studying what works and why. Solutions are then identified which grow out of the root causes of past successes. When people come together to identify and study examples of when they have experienced something going well (i.e. perfect handoffs, cross-unit teamwork, and exceptional patient care), they become enthusiastic, generate innovative solutions to their challenges and they become motivated to implement them.

## **Implementation**

IPI worked with the nursing team using a simple but powerful change framework known as the 5-D Cycle<sup>1</sup> (Definition, Discovery, Dream, Design, and Delivery). This cycle encompasses a series of dialogues, interviews, innovation mapping, goal-setting and self-organizing implementation activities.

The 5-D Cycle began by developing questions that would generate productive conversations about times when the ED-Telemetry patient handoff process worked well. One question asked nurses to recall a time they experienced the handoff *“in a way that you would describe as nearly perfect or exceptional... that if it had been videotaped, it could serve as a teaching tool for handoffs throughout the hospital system.”* Another question asked: *“What exactly did you do and what other factors in the organization contributed to this exceptional patient transfer?”* In order to ensure that new ideas for improvement were also captured, another question asked was: *“If you could go back in time with a magic wand and do this handoff over again, what could be done by you or others, or by changes in systems or procedures – which would take the handoff process to the next level - to make it world class from both a patient safety/satisfaction basis and from the perspective of employee satisfaction.”*

Over a four-week, period nurses from the Telemetry Unit interviewed nurses from the ED, and nurses from the ED interviewed nurses from the Telemetry Unit. A group of ED and Telemetry nurses then came together for a two-day working session to review the data they collected from their interviews. This data collection approach proved to be extremely powerful. It helped the nurses to shift from problems to possibilities and generated a wealth of innovative solutions and support for changes.

*“These questions enabled us to learn about the root causes of our success. This is critical when you’re working under pressure with someone’s life at stake,”* said one nurse. *“It was refreshing. As nurses we’re trained to look for problems so we can make people better. We have to. Focusing on things we’re proud of felt good,”* said Marcia McGregor, Nursing Director of Telemetry.

The team studied the data, including “handoff success factors,” in detail and created a grounded vision of what it would look like if every handoff were exceptional. *“The solution just made sense,”* said Amy Doran, Administrative Director of Emergency Services, *“Do more of what works, rather than studying problems, and we should see immediate improvement. And we did”.*

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<sup>1</sup> Watkins JM and Mohr BJ., Appreciative Inquiry: Change At the Speed of Imagination, San Francisco, CA: Jossey-Bass; 2001.

The interviews and conversations not only allowed the nurses to share their best practices with each other, but they also had the added benefit of strengthening relationships across levels and between the two units. As one telemetry nurse put it, *“We’d welcome the patient to the unit and say hello to the nurse. The nurse was doing her job as she was supposed to. Now we’re friends, we talk more frequently and work better together.”* And that has translated into new levels of patient care.

## **Innovations**

During their working session the team identified and planned five project innovations that would improve the handoff process, increase patient safety and improve employee and patient satisfaction. Nurses then volunteered to begin implementing these innovations.

1. **Welcome Script:** ensures that important information is communicated by nurses to each transferred patient.
2. **Safety Assessment:** acts a mechanism for nurses to initiate important treatment actions for patients.
3. **Standardized Transfer Report:** document that includes patient status, treatment, and a follow-up plan, and that standardizes information to be shared between nurses.
4. **Low Risk Cardiac Transport Protocol:** enables the transfer of certain low risk patients from the ED to the telemetry unit without the use of a cardiac monitor. Prior to the development of this protocol, transfer without a monitor was not an option. Each patient transferred without a monitor saves 30 minutes of nurse time allowing ED nurses to remain in the ED and care for their patients.
5. **Improving Mutual Interpersonal Relationships:** allows ED and Telemetry nurses to spend time observing a colleague in the alternate unit in order to better understand the responsibilities and challenges experienced by their counterparts in other departments.

## **Outcomes**

The following outcomes were achieved within the first six-months, or less:

- Up to 9.3% improvement in nurse satisfaction and teamwork; stronger interpersonal relationships among front line nursing staff and interest in further improvements;
- An overall increase of 10.2% in patient satisfaction
- Increased rates of patient assessment (with an 11% increase in completion of nutritional assessments and a 70% increase in completion of skin assessments)
- Significant improvements in compliance with cardiac enzyme regimen (9.2%) and medication administration records (81.8)
- A 60 % increase in the number of patients able to be transported without a cardiac monitor – with resulting cost savings of 67.5 hours of nursing time saved in per month

NBMIC is currently at work spreading these handoff innovations to handoffs across all telemetry and medical/surgical Units. *“IPI’s strengths-based improvement process [Appreciative Inquiry] enabled us to leverage our staff’s ideas”* said Shendell-Falik. *“Bottom-line, we measurably improved patient safety and created an exceptional work environment.”*

### **For additional information, please contact:**

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