

## **Synergistic Effect of the Organizational Culture on Quality Measures in Critical Care**

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**Purpose and Rationale:** Development of a culture of patient safety is critical in the Intensive Care Unit (ICU) where patients are most susceptible to hospital acquired conditions. An 850-bed academic medical center introduced a number of evidence-based practice measures aimed at improving the quality of patient care. Parallel to that process, the hospital system forged forward in the journey of High Reliability. Included in the messaging to the hospital personnel was that patient safety is paramount in all decision making and these beliefs were embedded in staff daily work and communications. Incorporating such cultures change initiatives that at the point of impact are an essential component of success.

**Research Question:** Can organizational culture shifts positively influence quality metrics in critical care?

**Synthesis of Review of Literature:** Best practice evidence for reducing hospital acquired conditions is well described in the literature.<sup>1</sup> Critical elements of a culture of safety include development of standard work and communication, universal accountability for safe patient practices, involvement of key stakeholders and development of blameless adverse event monitoring.<sup>2,3</sup> Culture transformation requires unwavering leadership dedication at all levels of the organization.<sup>4</sup>

**Methods and Procedures:** Over a three year period, the organization hardwired their formal communication strategy (H3W). Additionally, all staff members were required to attend High Reliability Training as well as Leadership Behavior Classes. Organizational leaders brought to life the Principles of Lean Daily Management. Included in the culture shift was the notion of transparency and open communication surrounding patient outcomes. Any safety concerns were discussed daily in the Patient Safety Action Group (PSAG) with included leadership from throughout the hospital. The information from PSAG flowed directly into the daily huddle processes on each individual unit. This allowed for the improvements and sustainability of the change processes. Evidence-based methods to prevent hospital acquired conditions were integrated into the clinical areas using these same huddle process and H3W forums. The cultural shifts of the organization in combination with the evidence based practice measures lead to the sustainability of otherwise overwhelming efforts.

**Results:** Critical care quality metrics improved over a two year period, and included reductions in Catheter Associated Urinary Tract Infections (CAUTIs), Central Line-Associated Blood Stream Infections (CLABSIs) and Hospital Acquired Pressure Ulcers (HAPUs). Data will be shared on the poster.

**Discussion/Application to Practice:** Evidence-based practice provides institutions with an outline of the procedures and methods to improve patient outcomes. However, the best outcomes for the patients are grounded in an organization that provides the proper framework for success; most notably, a culture of safety. When these key elements are combined, there is a synergistic effect to improve patient care.

## References:

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