

# ***Charting the Course for Home Health Quality: Action Steps for Achieving Sustainable Improvement***

## **Learning from Operational Failures in Home Health Care**

### **Executive Summary**

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## THE ISSUE

*How can health care organizations leverage their employees' experiences and knowledge?* This question is of paramount importance for creating sustained improvement in care delivery processes. “Operational failures”—defined here as disruptions or errors in materials, information, or resources necessary for patient care—can frustrate employees, reduce effectiveness and, at worst, jeopardize employee or patient safety. However, failures and the resulting frustration need not be the norm.

Under the right circumstances, employees' experiences with operational failures can provide a powerful catalyst for organizational learning and change. In order for managers to foster employee behaviors that lead to organizational improvement rather than frustration, they need to be aware of operational failures, understand their root causes and devise strategies for promoting and supporting effective problem solving within their organizations.

## PAPER OBJECTIVES AND METHODS

Despite the potential benefits of information about operational failures, surprisingly little is known about the numbers and patterns of failures that occur in home health care. *This paper provides a framework for describing such failures, analyzes two types of nurse response, and suggests ways that home health agencies can promote more effective organizational learning and change.* The purpose of categorizing operational failures by sources is not to place blame—especially on an individual—but rather to point to the areas that need to be addressed when framing problem solving strategies. The framework, data and examples that inform the paper come from a qualitative study of nurses at nine U.S. hospitals, survey responses from 834 nurses at 21 hospitals, and a day in the life of a visiting nurse.

## *The Framework*

For clarity, it is useful to distinguish between both the types of failures and their apparent source. Two types of failures are: (1) problems—insufficient (or inappropriate) supply of materials, support services, or information that obstruct a service provider's ability to accomplish a task; and (2) work system errors—the execution of a task that is either unnecessary or incorrectly carried out. The distinguishing characteristic of work system errors is that they waste resources by creating non-value-added time or rework.

The sources and causes of problems and work system errors are as multiple and complex as the types of failures that can occur. As a starting point for home health, we categorize sources into three main categories: (1) patient/family, (2) home care organization—including nurses, and (3) the larger health care system.

## *Types of Problem Solving*

Two avenues can be used to accomplish prevention-oriented problem solving. On one hand, organizations can rely on individual nurses to create positive change on their own. These highly motivated individuals can respond to the failures they encounter and try to rally resources to address the issues. This "individual problem solving" strategy is sometimes an explicit organizational strategy but probably more often the strategy of default. On the other hand, organizations can seek to establish a work environment and work groups that operate in concert to address failures that impact patient care. Under this "system-based problem solving" strategy, improvement is part of everyone's job throughout the organization, not just a few highly motivated nurses.

## FINDINGS

### *Types of Problems*

- During six hours in one day of the home care nurse, a total of 23 potential failures were observed – an average of one every 16 minutes. In comparison, the observational study of nine hospitals yielded a database of 194 operational failures, an average of one failure every 70 minutes.
- Half the home health care failures observed (52%) were attributable to patient/family issues, suggesting that resolving failures on the front lines of care require systems to facilitate communication and negotiation across boundaries rather than individual training or preparation. In addition, nurse-identified failures stemmed primarily from job design decisions originating from the visiting nurse agency, such as lack of tools (cell phone), task allocation (nurses having to make phone calls rather than office staff), and inaccurate estimates of cycle time (inconsistency between actual time required to document patient visits and standard procedure/ battery life for portable computer). These failures highlight the potential benefits of addressing failures at a system, rather than individual, level.

### *Types of Problem Solving*

- In the hospital, nurses typically employed “work-around” problem solving: in 93 percent of observed cases, they responded to operational failures by quickly patching the immediate problem, without engaging in additional behaviors that could facilitate organizational improvement. This was observed in the home care situation as well.
- For seven percent of the hospital incidents observed, nurses engaged in “prevention-oriented” problem solving that involved either trying to make an organizational change themselves or communicating about the failure to someone in a position to change underlying causes. Field observation of home care was too brief to allow observation of the prevention-oriented mode.
- In the home care setting, the high number of failures that likely result from patients' or family members' actions suggests that this is an area where prevention-oriented problem solving could produce a high payoff.
- Similarly, given the importance of nurse-physician communication regarding medications, as well as other critical aspects of patient care, structured efforts to improve nurse-physician communication potentially also could substantially reduce operational failures.

### *Impact on Nurse Satisfaction*

- In hospitals, nurses who belong to a unit that systematically addresses operating failures report higher job satisfaction.
- In contrast, nurses in hospitals that rely on individual problem solving are more likely to report job dissatisfaction and frustration.
- Brief field observation in home care, reinforced by survey data from hospitals, suggests that unless managers take an active role in both eliciting and trying to respond to employees' concerns and suggestions regarding trouble spots, the most motivated employees may burn out.

### ***Correlates of Prevention-Oriented Problem Solving***

- Prevention-oriented behaviors typically occur because there is a window of opportunity to communicate.
- Prevention-oriented problem solving is more likely to occur when the work design allows for frequent or planned interaction between nurses and key decision makers as well as a culture that values communications about failures and uses them to bring about positive change.
- Given the inherently individualistic nature of home health care, the challenges of creating organizational learning from individual employees' experiences are particularly formidable.

### **IMPLICATIONS AND RECOMMENDATIONS FOR HOME HEALTH CARE**

Learning from failures requires deliberate managerial interventions to counteract the more typical quick fix response. Managers have more leverage when they create system-based problem solving than when they rely on individually based efforts.

At the same time, by creating an organization-wide environment that supports problem solving at the local level, managers can create a system of coordinated improvement efforts collectively owned by the work group.


#### ***What can managers do to facilitate system-based problem solving?***

- Employees need to feel safe talking about failures, a concept called psychological safety. Thus managers should protect employees who voice concerns or raise awareness about system shortcomings and human errors.

- Managers should actively seek out information about failures. They should create systems for reporting operational failures that reflect the demands of the home care environment.
- Data collection ideally should be built into work processes so that no additional effort is required.
- Managers must demonstrate that they value and use this information to make positive change, a concept called problem solving efficacy.
- Among the actions the supportive actions that managers can take to create a sense of psychological safety and problem solving efficacy are:
  - o Designate a *resource person* to assist nurses in addressing operational problems.
  - o Establish a specific group to work on *improvement projects*.
  - o Institute *rapid cycle improvement experiments* that provide rapid feedback and avoid large-scale efforts that get bogged down and cause people to feel like "nothing ever changes."
  - o *Publicize the process and the results*.

### **CONCLUSIONS**

To prevent operational failures from recurring, managers need to integrate systems for problem resolution into the routine work of nurses. To design effective improvement systems, it is first necessary to understand the nature of operational failures in home health care. This involves categorizing operational failures and identifying their sources. The biggest areas of opportunity are likely to be problems and work system errors related to 1) insufficient support from home care agencies, 2) coordination failures with patients and their families, and 3) barriers to effective nurse-



physician communication. Second, employees must be encouraged to communicate about failures and attempt solutions. Finally, when employees do communicate, managers must act on the information, providing solid evidence that they value the information and are committed to using for improving the work environment of staff and the performance of the organization as a whole.