Reliability Between Nurse Managers: The Key to the High-Reliability Organization

Executive Summary

Nurse managers are the keys to building high-reliability organizations (HROs) in health care.

In HROs, staff can substitute, step in, and take over the care of the patient in a seamless manner.

Consistency between units occurs when there is a coherent pattern of safe practice guidelines.

The nurse manager council can become the powerhouse to seek out evidence-based practices and to insist on flawless execution between groups and units.

In health care, we are learning from high-reliability organizations (HROs) how to improve safety and outcomes. A challenge for us is to move from our bureaucratic-autonomous structures to integrate reliable and consistent processes and procedures throughout the organization. Nurse managers are the most important keys to embedding consistency and reliability throughout the organization and, therefore, are the keys to building HROs in health care.

Important research findings from HROs (Roberts, Yu, & van Stralen, 2004) include (a) emphasizing reliability over efficiency, (b) recognizing that risk exists and embedding strategies to prevent it, (c) making sure that the different perceptions and meanings people draw from their situations are integrated so that everyone is on the same page, and (d) migrating decision making to the part of the organization where the expertise lies. In addition, redundancy is built in, formal rules and procedures are spelled out and followed by all organizational participants, and there are enormous amounts of training.

Nurse managers are the most important element to implementing these findings in health care. It is only through consistency, collaboration, dialogue, and continued conversation between nurse managers that we will achieve excellence in patient safety. When a group of nurse managers is working in a synergistic mode, the patient will have much better outcomes than models where there is competition and lack of a shared vision about consistency and reliability within and between units.

Consistency/Reliability Between Units

Patients move between units and so do physicians, respiratory therapists, nurses, and many other health care personnel. When units have different procedures, are organized differently, do not have materials available in the same area in each unit, and have different models of nursing, layers of complexity are added to the professionals’ tasks. This increases the risk that something will go wrong.

There is a natural tendency to customize the unit to the needs and wants of the people who work there. However, this approach ignores the fact that this unit is just one of many in a system that cares for patients. Developing very different and inconsistent procedures and processes between units increases the risk of error. This is a very controversial issue because people often think about their unit’s wants and needs without evaluating how they are helping or hindering the work of others in the system.

In HROs, staff can substitute, step in, and take over the care of the patient in a seamless manner. Think about how airline pilots substitute for one another because there are consistent processes for flying airplanes. This can only happen if there is consistency and reliability between the processes that caregivers utilize. For example, if one nurse measures pain one way and another nurse uses different assessment questions, there is no reliability between caregivers. And if units use different assessment and intervention tools, an unreliable system exists.

Auditing the Risk

High-reliability organizations are preoccupied with failure. They proactively look for opportunities for people to make mistakes and then make changes in processes and procedures to prevent them from happening. One of the greatest opportunities to make mistakes in the interaction between units or shifts is when the patient is handed off to a different set of caregivers. The manager can deal with these issues on her/his unit only, but in a systems-thinking mode, the manager thinks about the big picture and builds consistency between units.

Safety rounds are an effective strategy in auditing risk. During rounds nurse managers can ask staff: “Tell me what kind of error you worry about making the most? Tell me about a work-around that you had to do because something doesn’t work as it should. Tell me about the last near miss you had. What is the
most unsafe practice when you move patients between units?” It is important that this kind of information be shared with all units everywhere.

The Solution? The Nurse Manager Shared Leadership Structure

The powerhouses to get things done are the nurse managers. When this group is working in synergy, magic happens everywhere. When nurse managers are not operating off the same page, chaos results. Historically, hospitals have been organized in the old bureaucratic modes of independent units/departments that were not required to collaborate with each other. Those models won’t work any more.

Kolind (2006) believes that a new paradigm is needed to help organizations move into the collaborative organizations that are essential for survival. He suggests building four pillars to support the organization: (a) the organization has meaning beyond making a profit or being big, (b) involving a fundamental partnership between management and staff, (c) organizing for collaboration, and (d) leading based on shared values rather than authority and power. These organizations are based on a shared contract rooted in values and norms and not on the old paradigm of authority, autonomy, and power. Work should be organized around continuous effort and not the one-time efforts of old models (Kolind, 2006).

These four pillars are an excellent organizational framework around which nurse managers can build a collaborative practice model for the organization. Nurse managers are largely responsible for the culture of their unit. What they reinforce and what they do not becomes the accepted behaviors on the unit. Unfortunately, if one surveys an entire group of nurse managers in a facility, the results will probably reveal great variability between managers and the cultures they create. Some managers are punitive and blaming when mistakes happen; others create a learning environment where near misses and mistakes are analyzed and learning takes place. Some nurse managers collaborate with other units and set cooperation as a standard among their staff; while others openly criticize other units and staff. Some nurse managers implement programs such as family-centered care to the fullest; others give this practice only minimal attention. Nurse managers need a shared vision of the activities, cultures, and processes on all units. Standards of collaboration between units must be developed and implemented. Agreement and lack of variability between nurse managers will lead to a HRO structure.

Consistency between units occurs when there is a coherent pattern of safe practice guidelines that provide the formal operating guidelines about how practice should occur. Murphy (2006) defines this process as “...not the pursuit of perfection, but the pursuit of a method of operation that when done correctly can be replicated by the organization” (p. 4). From his experience as a fighter pilot, Murphy (2006) learned the process of Plan-Brief-Execute-Debrief-Win that has led to flawless execution among fighter pilots as well as in business. Many accidents happened between fighter pilots until processes and procedures were initiated and were consistent and replicable from one pilot to the next and from one plane to the next. This is our challenge in health care: to make sure we are implementing the best practice every time throughout the organization. Unfortunately it is not uncommon to find different compliance rates across units with documentation standards, pain assessments, etc. Medication reconciliation is an attempt to insert a common practice on all units to ensure the safety of patients getting the right medication in the hand-off process. If full compliance with this procedure on all units at all times is lacking, high-reliability practices and flawless execution are impossible.

In a shared leadership/governance organization nurse managers can establish meaning, develop partnerships, organize themselves for collaboration through these structures, and lead by basing their positions on shared values rather than individual autonomy, authority, and power. Nurse manager councils can organize themselves around the concepts of a high-reliability organization. To be effective, nurse managers must migrate from focusing solely on their own unit to seeing the big picture and doing what is right for the greater good. The nurse manager council can become the powerhouse to seek out evidence-based practices and to insist on flawless execution between groups and units.

Summary

Flawless execution rests in the hands of nurse managers. No one can work alone in health care any more. We are interdependent and know that the best outcomes happen when practices are organized around collegial supportive structures rather than autonomous competitive units. We are only as strong as our weakest link. If all managers see the big picture and look beyond their units for what is right for the common good, we will achieve high-reliability organizations in health care. In turn health care organizations will become very safe places to operate.

Shared governance structures for nurse managers are the perfect vehicle to develop collaborative organizations and flawless execution, and to adopt high-reliability organization principles.

REFERENCES

