Small Troubles, Adaptive Responses (STAR): Fostering a Quality Culture in Nursing*
A Mechanism to Increase Awareness of First Order Operational Failures in Med-Surg Units

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PROBLEM

▪In frontline nursing care, workarounds are a common response to small operational failures,[1] exposing patients to errors and creating inefficiencies in care.
▪Endemic shortages of nursing staff and difficult working conditions present substantial barriers on the path to improvement.[2]

EVIDENCE

▪Detection of first order operational failures provides opportunities to fix underlying system failures and contributes to organizational learning.
▪Failures occur about one per hour per nurse on hospital units and 95% of problems are managed through workarounds.[2]

STRATEGY

▪As part of a larger project on frontline improvement, index-sized pocket cards were used to self report problems occurring during work shifts.
▪This approach was developed by the STAR team to capture small problems encountered in daily practice.

PRACTICE CHANGE

Practice change consisted of using pocket cards to detect workarounds.

▪Staff on 3 nursing units used the cards to detect first order operational failures.
▪Small pocket cards were designed and tested; nursing staff recorded in real time the small operational failures encountered.
▪Operational failure categories were developed from prior descriptive work[2]
▪This increased awareness of small troubles encountered during routine care.
▪A summary of small problems was presented to the staff.

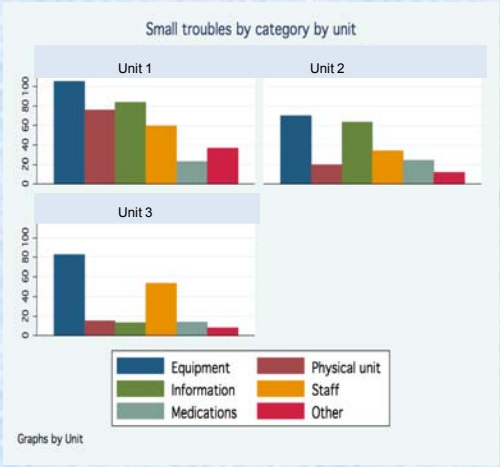
EVALUATION

▪The strategy was evaluated through cross validation of the card's ability to capture self-report of first order operational failures, identify problems and create awareness of common workarounds among nurses working in the units/ hospital microsystems.

▪Results were compared to previous findings [2] and confirmed by key informant interviews.

RESULTS

▪Over a 4-week period, 137 cards were returned reporting a total of 794 small problems.
▪Preliminary findings show staff reported about six small problems per twelve hour shift.
▪Type of small problems detected with pocket cards were comparable to those directly observed[2], with highest failures in equipment/supplies, staffing & communication.



RECOMMENDATIONS

•Nurses can effectively identify workarounds; thus the pocket card approach can be used to identify first order operational failures as a basis for improvement interventions.

LESSONS LEARNED

▪Careful planning is needed to encourage pocket card use.
▪Success depends on championing by mid managers/microsystem leaders.
▪A clinical-academic partnership can open new avenues for detecting targets for frontline improvements.

Bibliography

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