DESIGNING SAFETY INTO HIGH-RISK/HIGH-STRESS ENVIRONMENTS: POSITIVE INNOVATION FOR PATIENT HANDOFFS☆

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ABSTRACT

The high-risk/high-stress nature of hospital emergency departments has made handoffs (i.e. patient transfers across organizational units) an area of significant safety consequence, as evidenced by numerous studies and 2006 Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH). Joint Commission Resources, Inc.: Author; 2005. This same high-risk/high-stress environment is known for generating resistance to traditional deficit-based, external expert driven approaches to improvement. The authors describe how one hospital overcame this

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Designing Information and Organizations with a Positive Lens
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resistance by using an Appreciative Inquiry approach to the redesign of the information flow and organizational roles within a mission-critical area of the hospital. Rather than designing to ameliorate the root causes of ineffective handoffs, this positive lens approach (Appreciative Inquiry) was used to engage staff in identifying and expanding upon their most effective handoff experiences. Implications for shifting from problem-based design to a positive lens approach in the creation of micro-information systems and new organizational processes are discussed.

INTRODUCTION: CHANGING THE WAY WE CHANGE – A TWOFOLD CHALLENGE

In 1999, the Institute of Medicine pre-released "To Err Is Human," a groundbreaking and devastating report that estimated that medical errors of all sorts led to as many as 98,000 deaths each year – more than was caused by highway accidents and breast cancer combined. Health officials and hospital groups pledged reforms. In 2001, the Institute of Medicine released "Crossing the Quality Chasm" – a renewed call to action, but with little evidence of positive response to its initial report. In early 2004, HealthGrades (the leading US health-care ratings organization) released the results from a review of billing information for 37 million Medicare patients and found 195,000 hospital deaths from preventable errors occurred annually from 2000 to 2002. That was more than double the 98,000 preventable deaths cited in Institute of Medicine study of 1999. In 2006, The Commonwealth Fund Commission on a High Performance Health System created the National Scorecard on US Health System Performance, the first-ever comprehensive means of measuring and monitoring health-care outcomes, quality, access, efficiency, and equity in one report. The commission concluded: "across 37 indicators of performance, the US achieves an overall score of 66 out of a possible 100 when comparing actual national performance to achievable benchmarks."

The prescriptions called for by both the Institute of Medicine and the Commonwealth Fund Commission on a High Performance Health System are clear. This includes requirements such as "designing jobs and working conditions for safety; standardizing and simplifying equipment, supplies, and processes; and enabling care providers to avoid reliance on memory." The theoretical frameworks and methodological tools (of socio-technical systems) to accomplish this are easily available, with powerful evidence to support their efficacy. In light of this, obvious questions arise – why has

progress been so slow in an arena that can legitimately be said to have life and death consequences for so many people and that has such a seemingly powerful "case for action" to support improvement? "Resistance to change" is of course the common diagnosis in such situations.

In health care, resistance to change represents a twofold challenge:

- Resistance to change at a generic level (i.e. not enough time or budget, what can people who are not physicians know about our work, etc.)
- And, in particular, skepticism about whether Appreciative Inquiry and its participative, positive lens approach (so different from their culture of disease, pathology, and hierarchical organization) can really work in an environment characterized as high risk/high stress, where everyone is "already too busy," and on issues (such as patient safety) that are seen as "mission critical," needing immediate results and payoffs

Paradoxically, Appreciative Inquiry and its positive lens approach to redesign may have the ingredients needed to respond to both challenges. Let us explore each one.

In *Feedback From the Positive Question*, Sorensen and Yaeger (2004) show how Appreciative Inquiry deals with reasons for resistance that are generically applicable to any sort of significant change. Table 1 draws upon their conclusions and adds our own experience.

This leaves the issues of skepticism about whether Appreciative Inquiry and its participative/positive lens approach can really work in an environment characterized as high risk/high stress, where everyone is "already too busy," and on issues (such as patient safety) that are seen as "mission critical," needing immediate results and payoffs. The authors invite the reader to decide how the following case addresses these very important questions.

Once you have drawn your own conclusions, we offer an epilogue to the case, in the form of our reflections on these questions.

Project History and Rationale

Newark Beth Israel Medical Center (NBIMC) is a 673-bed hospital based in Newark, New Jersey. This hospital has over 60% of patients admitted from the emergency department and over 80,000 emergency department visits a year. Patient transfers from one caregiver to another are an area of high-safety consequences. Every time a patient is moved, there is a risk that essential information regarding care will not be communicated. Time

Table 1. How Appreciative Inquiry Reduces Resistance to Change.

Reason for Employee Resistance	How Appreciative Inquiry Reduces Resistance
• Fear of the unknown (i.e. "we know what we have, but we do not know what change will bring"). • Change can cause people to question their ability to prosper in the future state. • People like the old system.	In addition to creating a clear picture of what the change will bring (novelty) and how we are going to get to the future (transition), a unique feature of Appreciative Inquiry is its focus on what will remain the same (continuity). With this unique focus on retaining the best of the present/past and the creation of a future vision based on peak experience stories from the past, employees gain confidence about their ability to succeed in the future and are attracted to the implication that non-peak experiences will be reduced.
• People feel imposed upon by the organization – they ask "what's in it for me?"	Beginning with the paired interviews that explore personal peak moments and invite people to create a future that has more moments like that, the Appreciative Inquiry approach puts the "benefits" of the change into very personal terms.
• People are skeptical that this is yet another fad. Why invest in something that may be forgotten next month? This skepticism drains the critical energy needed for new ideas and their implementation.	For most people, the invitation to identify and build upon their strengths is sufficiently provocative and attractive to "get them into the room." Further participation in the *Discovery* and *Dream* phases of Appreciative Inquiry serves to dislodge their certainty that this is "business as usual" while generating a level of energy commensurate with the celebratory and inspirational nature of those activities. This "affective fuel" and the "grounded" nature of the future images provide the necessary foundation for the harder work of *Design* and *Destiny/Delivery*.

constraints require nurses to share essential information quickly, but nurses self-report that the information they provide and receive when a patient is transferred is highly variable from nurse to nurse and impacts patient safety (Hardey, Payne, & Coleman, 2000; Hays, 2003) as well as their own job satisfaction. Competing priorities to achieve safe, timely, effective, and efficient patient care (McKenna, 1997; McLaughlin, Antonio, & Bryant, 2004; Currie, 2002) made redesign of the patient care process extremely challenging – requiring a process that was fast, comprehensive, and evidence based and would generate results more quickly than the multitude of more traditional deficit-based quality improvement processes. The opportunity to increase patient safety also required an approach to change that generated energy and commitment in the early stages – defined as the first six months.

Nancy Shendell-Falik, the vice president of patient care services, and the external resources (Michael Feinson and Bernard Mohr from Innovation Partners International (IPI)) agreed that the highest payoff would come from an approach that improved *simultaneously* patient safety, quality of care, and nurse satisfaction. Shendell-Falik and the consultants also agreed that success would come from focusing on improving the core work of the organization – something highly amenable to a process of conscious design, rather than a "downstream" element like "culture." It was hypothesized that cultural change (also a desired result) would be a natural consequence of engaging those closest to the organization's core processes in generating hard results through the use of a process (Appreciative Inquiry based design) that itself embodied the desired cultural values of collaboration, responsibility, and a possibility focus. A relationship-centered, participatory action research approach, called Appreciative Inquiry, was chosen to analyze, redesign, and implement changes in the patient transfer process.

The project followed a simple, but powerful, change framework: *Definition–Discovery–Dream–Design–Destiny/Delivery*, known as the 5-D cycle. This cycle encompassed a series of dialogues, interviews, innovation mapping, goal setting, and self-organizing implementation initiatives. (Please refer to the later section, "Positive Design In Action," for more information about the 5-D cycle.)

CHOOSING THE POSITIVE LENS AS OUR APPROACH TO REDESIGN

This project began with the assumption that the best ideas to improve the handoffs between the emergency department and the A6 telemetry unit would come from those individuals who worked closest to the process. Engaging those staff members closest to the process in developing solutions to improve it was itself a minor cultural innovation. However, it paled beside the choice of approaching redesign with the positive lens of Appreciative Inquiry. The usual hospital/medical approach of identifying the problem (i.e. the disease), comprehending the root causes of it, and exploring solutions was considered. This traditional "deficit based" approach has achieved progress in the past, but its limitations are increasingly apparent. The problem-fixing approach typically does not foster excitement and enthusiasm for the task at hand nor does it generate innovations beyond the parameters of the defined problem. The deficit approach often leads to defensiveness as people resist being identified with aspects of the problem.

Appreciative Inquiry is an alternative approach to organizational and process design. This technique acknowledges problems and assumes that there are successes and things that are working well, which could provide learning and fuel to overcome problems. It succeeds by engaging groups in studying what works and why and then building solutions based on the knowledge identified and the human energy generated by the process. New insights into moments of optimal performance, the system's strengths and resources, and what the organization looks like at its best are used as the foundation to help the institution achieve its desired future. The result is more useful structures, processes, and ways of working differently, as well as an increased sense of commitment and enthusiasm to the organization (Ludema, Whitney, Mohr, & Griffin, 2003). The positive, inclusive, and inquiry-based nature of the Appreciative Inquiry approach is what differentiates it from deficit approaches and leads to these benefits.

As a philosophy, Appreciative Inquiry invites people to consciously choose to seek out, inquire into, and build on what is generative and life enriching – both in our own organizations and elsewhere. It invites inquiry into the true, the good, and the functional in our history, along with an exploration of people's hopes and wishes for what should be created that does not exist now.

As a change process, Appreciative Inquiry engages people in building the kinds of organizations and world that they want to live in, by bringing people together to collaboratively identify those factors that give a system or organization "life" when it is most effective and capable in economic, ecological, and human terms. Appreciative Inquiry then provides methods for weaving that new knowledge into the fabric of the organization's formal and informal infrastructure (i.e. systems, roles, processes, structures, etc.).

Appreciative Inquiry is a natural fit for health-care organizations, not only because it is evidence based (utilizing people's actual experiences and the information available from whatever other sources are deemed relevant), but also because it is a highly inclusive and hopeful process of inquiry and action. Additionally, Appreciative Inquiry helps build relationships among key stakeholders because it encourages people to identify, engage, and strengthen the core values and "life-giving forces" within the organization. This has parallels within the health-care providers' role of treating the mind and body to help people live optimally. We have found that when organizations and teams focus on "what's wrong" (i.e. low morale, poor communication, ineffective processes, etc.), the people involved become discouraged and less hopeful that the "problems" will be corrected. Often after meetings focusing on problems, participants indicate how their

awareness of the problems has increased and they express how this new attentiveness to the problems impacts them in an even more negative way. In addition, they leave with a clear understanding of what causes the problems and what *not* to do to prevent the problems from reoccurring. At the same time they continue to lack focus on what they *should* do to improve performance.

Alternatively, when individuals come together to identify and study examples of when they have experienced things going well (i.e. high employee engagement, great handoffs, exceptional patient care, etc.), they tend to become energized and more creative in identifying possible solutions to resolving their problems. They also take ownership in design, planning, and implementation of the solution because they were the ones who created the solution.

Appreciative Inquiry was selected as the overarching approach to facilitate this redesign of the emergency department to telemetry handoff process for the following reasons:

- It shifts people's focus from problems to possibilities, from what cannot be done to what can be done, from getting back to previously identified levels of functioning to going beyond what was thought possible, and lastly, but not insignificantly, from the despair of organizational pathology to the hope of human vision.
- It is a highly inclusive, energizing process that could yield results in a short time while at the same time arousing the staff's interest in further improvement. A deficit-based approach would more likely have exhausted the team and left them feeling less hopeful.
- NBIMC was committed to using an approach that would generate positive energy and commitment, but it also wanted the approach to have flexibility and scientific grounding. Appreciative Inquiry is grounded in extensive research on the connection of human behavior to the images that people hold in their minds, the language and words they use, and the emotions they experience (Cameron, Dutton, & Quinn, 2003). Rather than a lock step tool or technique, Appreciative Inquiry allows flexibility because it is built on fundamental principles (Cooperrider & Whitney, 2001).

The research cited above suggests that the process of studying something and the beginnings of change are simultaneous – with the organization moving in the direction of the questions it most frequently asks. When we look for/study problems, we will find and create more problems. When we study/seek successes, we will find and create more of what we want. This

theory was seen to be very supportive of what NBIMC was hoping to accomplish.

POSITIVE DESIGN IN ACTION

This project was guided using a framework known as the Appreciative Inquiry 5-D cycle (Fig. 1) (Watkins & Mohr, 2001).

This five-step cycle serves as a roadmap for applying much of the research discussed above to organizational improvement efforts. The first step of the cycle is called *Definition*. This begins the Appreciative Inquiry process with dialogues that reframe problems into affirmative topics. For example, a problem of high overhead costs is reframed as an inquiry into optimal margin, and a study of the causes of patient harm may be reframed into an

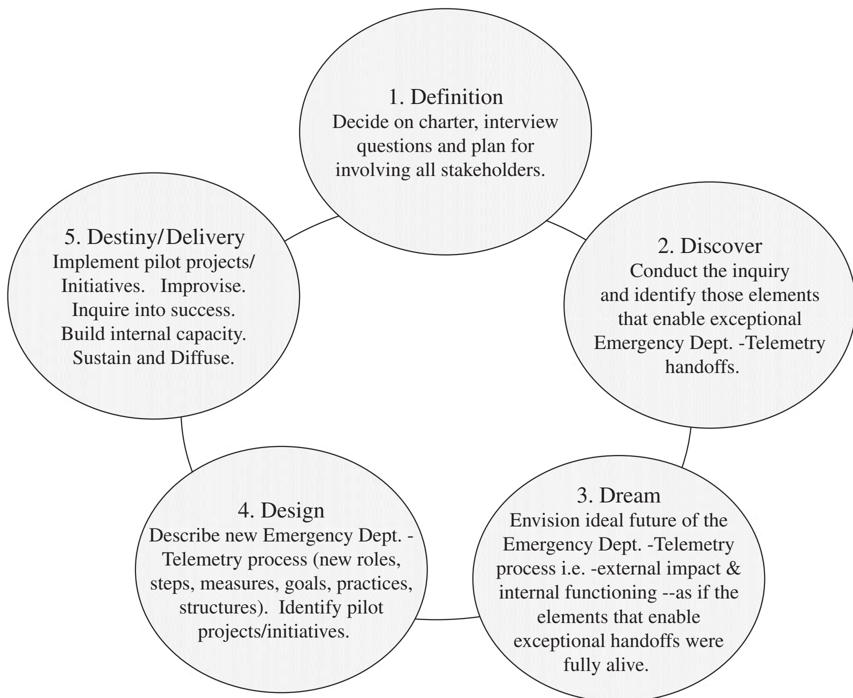

Fig. 1. Appreciative Inquiry 5-D Cycle for Emergency Department – Telemetry Handoff Redesign.

inquiry into outstanding patient safety. During this phase, agreement is reached on the scope of the work and the ways that members of the system will participate. During the *Definition* process at NBIMC, the consultants discussed with the vice president of patient care services and her senior staff the possible inquiry topics that would enable them to attain both her patient safety and employee satisfaction objectives. Initially, it was thought that a focus on work culture and job satisfaction would translate into improved patient safety and quality of care. This soon shifted to a focus on redesigning an actual process of patient care. "It just hit me when the consultants explained that improving working relationships and morale doesn't necessarily improve a work process and patient safety, but engaging employees to improve a process using a strengths-based approach, is likely to improve working relationships at the same time," said the vice president of patient care services.

The second part of the cycle, *Discovery*, includes paired interviews that are followed by sense-making dialogues that clarify the following:

- Conditions that support optimal performance
- Aspects of the past that are worth preserving/continuing
- Ideas/opportunities that exist for innovation

The nursing team and consultants collaborated to develop questions that would generate productive conversations about times when the patient transfer process worked well. (Refer to Appendix A for a copy of this interview guide.) Over a four-week period (which came after the initial "Definition" meeting in February 2005), nurses from the telemetry unit interviewed nurses from the emergency department, and nurses from the emergency department interviewed nurses from the telemetry unit. 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?" The cross-departmental interviews and discussions allowed the nurses to share their best practices with each other and had the added benefit of strengthening relationships between the two departments. One telemetry nurse described the change, "We'd welcome the patient to the unit and say hello to the nurse. The nurse was doing her job like she was supposed to. Now we're friends and we treat each other differently."

Next, a group of emergency department and telemetry unit nurses came together for a one and half day working session to review the data they had collected from their interviews. ''These questions enabled us to learn about our root causes of our success. This is critical when you're working under pressure with someone's life,'' 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 the nursing director of telemetry.

During this working session the team completed the *Dream* step of the 5-D cycle – engaging in dialogues that create compelling visions of the results they desire in the future. The group analyzed the interview data and examined the success factors of great handoffs. They then created a vision or dream (using storyboarding and skits) of what the handoff process would be like, if every handoff between the units were that exceptional. This concluded their *Dream* phase, and they then moved into the next phase – *Design*. Designing involves taking the *Dream* down to the specific changes to the process (roles, systems, structures, ways of working, etc.), which enable visions of the preferred future to come alive. The group again detailed their ''new'' handoff process by using the metaphor of a play. This time, though, they mapped the key ''acts'' (i.e. key phases of the work process) and the essential functions and activities that had to take place in each ''act.'' The final phase *Destiny/Delivery* invites participants to self-organize the implementation activities around those things that they are most passionate about. The group held dialogues about the following:

- Projects or initiatives that would move their vision (composed of both the higher level *Dream* and the more detailed *Design*) into daily practice
- Projects or initiatives that would have priority (based on passion and payoff)
- How, if at all, are the projects interlinked and what does this mean for implementation
- Who would work on which project (based on passion and the right resources to be able to get the work done)

Once these dialogues were completed they finished by agreeing on:

- An overall ''roadmap'' to the ''Ultimate Handoff Process'' – a chart that integrated all of the initiatives and pilot projects
- A list of stakeholders that would be impacted by the changes they were proposing and a plan for how to engage the minds and hearts of those stakeholders in both improving (as needed) and executing the changes

- A communications strategy for those not in attendance
- A list of outcomes they could measure to assess the impact of their efforts on patient safety, patient care, and employee satisfaction

In Table 2 – "Key phases, activities and accomplishments in the redesign of the NBIMC emergency department to telemetry handoff process" – we summarize what was done and accomplished within each of the five phases of the Appreciative Inquiry cycle – as it was applied in this situation.

IMPACT OF POSITIVE DESIGN ON QUALITY, PATIENT SAFETY, AND NURSE SATISFACTION

Short-term outcomes of this effort included the following:

- A "map" that serves as an overall guide to the "Ultimate Handoff Process"
- A new "low risk" cardiac transport protocol
- A new safety assessment form
- A welcome and handoff script (see Appendix B)
- A standardized transfer report (see Appendix C)
- A list of stakeholders that would be impacted by the proposed changes and a communication strategy for engaging those stakeholders in improving and executing the changes
- A list of measures for monitoring the impact of the redesigned process

The following outcomes were achieved and documented within six months or less:

- 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 regime and medication administration records that increased by 9.2 and 81.8%, respectively
- A 60% increase in the number of patients able to be transported without a cardiac monitor – with resulting cost savings of 67.5 h of nursing time per month
- An overall increase of 10.2% in patient satisfaction
- Up to 9.3% improvement in nurse satisfaction and teamwork

Table 2. Key Phases, Activities, and Accomplishments in the Redesign of the NBIMC Emergency Department to Telemetry Handoff Process.

	Definition and Start of Discovery Process	Continuation of Discovery Dialogues, Followed by Dream, Design, and Destiny/Delivery Process Dialogues	Continuation of Destiny/ Delivery Process	More Discovery, Dream, Design, Destiny/Delivery Dialogues
Key activities	Early January 2005, 5 h project-planning session February 2005 data collection interviews	March 1–2, 2005 1.5 day redesign session	March 3–May 2, 2005 Implementation	May 3, 2005 Taking stock session
Who was involved	22 person representative group of all the functions and levels of staff involved in the handoff process. This group was called the "core team"	Staffing constraints limited us to all the people from the core group plus a few others. However, voices of others not present were brought into the room via interviews conducted by core group members.	All core group members plus other staff in the emergency department and A6 telemetry unit	Same people present during the March 1–2 redesign session plus "interested outsiders"
What was accomplished	(a) Agreed on charter for this work, including • Purpose of this project • Why use the Appreciative Inquiry approach?	(a) Identified elements of the handoff process (human, technical, and organizational) which are strong and should be maintained or built upon	During the next two months, the members of the core group implemented the innovations (adjusting them as needed).	(a) Celebrated accomplishment so far (b) Solidified learning about how positive change happens by reflecting on the best of the last two months

- A vision of the positive benefits we will have achieved when this redesign process is successful
- Roles of core team, process owner, and redesign team
- Key phases, activities, and timing for the redesign process
- Metrics to be used to measure process performance before and after
- Critical success factors *and* parameters for redesign process
- Agreed on desired outcomes and preparation for the March 1–2 redesign session
- Defined for the emergency department–telemetry handoff process
  - Boundaries (inputs and outputs)
  - Key Stakeholders

(b) Identified additional individuals to participate in the March 1–2 redesign day session and how to invite them

(b) Developed the ideas for process improvements and innovations *and* what those ideas would look like in a fully functioning mode

(c) Agreed on what improvements and innovations within the emergency department–telemetry handoff process would have the greatest impact in improving patient safety and quality of care. The five broad areas of innovation were identified as:

- Development of a welcome script
- Safety assessments
- Standardized transfer report
- Low-risk cardiac transport protocol
- Interpersonal relationships

(d) Clarified the steps/actions for the innovations with most promise that people were to take

(c) Identified how to build on what we accomplished in emergency department and telemetry unit

(d) Worked on existing/new projects

(e) Clarified how to best spread the innovations we successfully implemented, within other parts of the hospital

Table 2. (*Continued*)

	Definition and Start of Discovery Process	Continuation of Discovery Dialogues, Followed by Dream, Design, and Destiny/Delivery Process Dialogues	Continuation of Destiny/ Delivery Process	More Discovery, Dream, Design, Destiny/Delivery Dialogues
	(c) Agreed on next steps. • Data to be collected prior to March redesign session and how and by whom • How to communicate about this meeting, to whom, by whom, how, etc.?			

- Stronger interpersonal relationships among frontline nursing staff and interest in further improvements
- Other telemetry and medical surgical units at NBIMC have begun to adopt these improvements

POSITIVE DESIGN IN HIGH-RISK AND MISSION-CRITICAL ENVIRONMENTS

In Cooperrider and Avital's (2004) *Advances in Appreciative Inquiry – Constructive Discourse and Human Organization*, Appreciative Inquiry is described as "a mode of practice (which) aims at designing and crafting human organizations." High-risk/mission-critical environments need design processes that are powerful yet simple (i.e. not ones that sink under the weight of their own complexity). As a practical approach to the redesign of information flow and organizational tasks/roles, Appreciative Inquiry is quite simple to comprehend and use. Its five basic processes (Mohr & Watkins, 2002) are as follows:

1. Choose the positive as the focus of inquiry.
2. Inquire into stories of positive exception/positive deviations – and identify the systems capabilities that made those moments possible.
3. Combine that knowledge with individual aspirations and opportunities in the environment to create "grounded" images of a preferred future.
4. Design innovations in information and organizational task/roles that will compel the realization of the preferred future.
5. Implement, re-inquire, and improvise modifications.

In high-risk/mission-critical environments, the tolerance for delayed results is low and the requirement for fast diffusion is high. In retrospect, NBIMC appears to have accrued two major benefits by choosing to use Appreciative Inquiry:

1. It accomplished its desired changes in a short period of time.
2. It increased staff's interest in further changes that would improve patient care.

These are powerful benefits and may serve as a rationale for others to use the Appreciative Inquiry approach. However, the following three additional conditions, which existed at NBIMC, should be considered as highly

desirable, if not essential:

1. Commitment from a champion: From our experience, the most successful organizational improvement initiatives are those that have a champion whose role is to follow up on projects, communicate successes, and keep things on track. NBIMC had three such individuals: the vice president of patient care services, the administrative director of the emergency department, and the nursing director.
2. A belief that solutions lie within the people: Studies show that up to 70% of organizational improvement efforts fail to produce the expected results (Hammer & Champy, 1993). In the majority of cases, these efforts fail or go over budget not because the technical solution is wrong, but because the people side of the change was managed in a way that did not build employee ownership and support. The vice president of patient care services acknowledged that some of the ideas generated by the staff were not new ideas, but had she told people to implement them she would have gotten compliance, not the 100 percent commitment she needed. Engaging all staff (or as many as possible) that would be impacted by the changes into the process almost guaranteed more innovative ideas and the level of commitment necessary for success.
3. Quantum, rather than incremental, change is sought: when the desired changes are step factor changes, rather than doing things just a little bit better (e.g. elimination of green house gasses vs. a 5% reduction). NBIMC was not looking for a band-aid approach that would moderately improve the handoff process. Like most hospitals, it was looking for a solution with measurable, significant, and sustainable outcomes.

Finally, it is our experience that while all organizational environments value the opportunity to "put a toe in the water" before committing to a new change process, this is particularly true of high-risk/mission-critical environments. In this aspect, Appreciative Inquiry offers additional value since it can easily be applied to an unlimited number of personal and work-related situations. Here are some simple ways you can use it to promote conversations that improve relationships and lead to constructive actions:

- When someone says, "let's talk about why this meeting was so ineffective," ask if she would be willing to have each person describe
  a) what he or she saw as the best part of the meeting and to offer suggestions of how the team could do more of those things in future gatherings
  b) what an even higher level of team functioning would look like
  c) how the team could achieve that.

- Ask your spouse, best friend, or some significant other, "I'm curious about what you think of as the really great times in our relationship. Would you tell me about one moment that stands out for you as a highpoint for you? And what would our relationship look like if we could take it to the next level?"
- If you are going to evaluate someone's performance, ask him or her to tell you about the times when he/she felt most competent and productive. Then ask him or her what you both could do to increase the frequency of those times in the future.

OUR REFLECTIONS

Appreciative Inquiry, like many other inclusive approaches to the creation of desired futures, values the voices of stakeholders with diverse perspectives. The story you have been reading so far has interwoven the voices of the "partners in this design process" (i.e. the external consultants and Nancy Shendell-Falik, vice president, patient care services, NBIMC). In this section, we offer reflections on the types of questions typically asked by senior managers trying to decide whether a positive and high-participation approach to the design of information and organizational systems is right for their culture.

Applying the Positive Lens in Mission-Critical, High-Risk, and Busy Environments

Many executives wonder if Appreciative Inquiry and design with a positive lens approaches are too esoteric for their visible, mission-critical, high-risk, and busy environments. They believe that what is needed is a more problem-focused approach with immediate payoffs.

In hospitals, managing the risks to patients' lives is a prime focus in what often seems like a perpetually understaffed situation. In this sort of environment, the work of each day is determined by that day's problems, and very little energy is left for going to the next level of performance. In fact, we think that employees live on the energy that comes from working in mission-critical processes. We also believe that thriving on crisis does not take you to the next level. Generating human energy as the fuel for non-crisis-based performance improvement is possible, and the Appreciative Inquiry approach provided that energy while also creating measurable outcomes.

This leads us back to the skepticism that some leaders might have about an approach that seems so "soft." While Appreciative Inquiry is strengths based, it does not ignore problem areas. It subtly shifts ways we approach them, with profound implications. Rather than focusing on problems and their causes, it focuses on learning from solutions that have already been successfully used. Also, Appreciative Inquiry uses the data gathering, analysis, goal setting, and re-engineering steps of other improvement approaches – just with that key twist of starting by learning from positive deviations, rather than negative deviations, in the system.

We also believe that some senior leaders confuse the decision to use an Appreciative Inquiry approach with the decision they make around what to focus their improvement effort on. One of the hospital's aha moments in this project came right at the start when we agreed that the best way to achieve rapid and measurable results was to focus our efforts on redesigning a core work process rather than pursuing something more esoteric, like cultural change, in the hope that it would someday lead to improvements in patient safety.

We are reminded of what one of the nurses said afterward: "The Appreciative Inquiry questions enabled us to learn about the root causes of our success. This is critical when you are working under pressure with someone's life at stake."

Our Success Factors and the Value of Collaborative Inquiry

We have seen positive results from problem based root cause analysis, but the investment of energy to get the solutions implemented is high, diffusion is challenging, and often the interpersonal side of the equation does not get effectively addressed. The Appreciative Inquiry based design approach in this situation created more energy to improve the human side of the equation. There was a lot of buy-in to trying new procedures and good sustainability.

There is also the question of applying the right expertise to a problem or improvement effort. Making patients who transfer from the emergency department to the telemetry unit safer was seen as critical to patient safety. But we could not say what new solutions the people in certain areas needed because none of us has ever been a telemetry nurse nor did we have the day-to-day experience of this particular workplace. It was the nurses who had the relevant expertise. In fact, because the process valued their expertise, we think this helped them to value each other.

Additionally, the staff found the approach to improvement surprisingly easy. They seemed to enjoy the project, and they did not need to use improvement tools that are hard to learn or that take a lot of training. Relationships flourished because of the positive solution oriented focus of this work. During the interview exchanges, as nurses developed ideas for innovation, they also became friends. Now they converse more frequently and more fully. This closer, smoother collaboration, along with the changes in roles, steps, and information flow, translates into improved and more attentive patient care.

The Contribution of Appreciative Inquiry to the Diffusion of Innovation

We had very good success with diffusion. We framed the initial project dealing with patient transfer from the emergency department to the A6 telemetry unit as a demonstration project, and now this approach has been expanded to all telemetry and medical/surgical units. The hospital has also successfully initiated a perinatal/neonatal handoff project. Again, we think the ease of the approach combined with the positive energy that is created had a lot to do with this. Of course, it helps that no one argues about the investment now because the initial outcomes are positive and the project has demonstrated value – at the levels of patient safety, nurse satisfaction, and cost reduction.

Two strategies that made it survive in the patient transfer from emergency department to telemetry "demonstration site" were the inclusive interviews at the start and the appreciative evaluations they were doing as they moved through implementation. It may take a little more time up front to involve everyone, and of course you cannot shut down an operation such as a hospital. You just need to be creative in how you build inclusiveness. We found that a series of shorter meetings supported by "off-line" interviews between those who attended the meetings and those who could not be there was a simple, but effective, form of inclusion.

The appreciative reviews we did at the mid-implementation point were also helpful. Usually those sorts of evaluations overemphasize the things that have gone off track or that have not been done according to plan. This may seem like the "logical" thing to do, but we found that by celebrating what we had accomplished and asking people what they thought could happen now, we were able to rekindle the enthusiasm and keep the momentum while learning about what works in our unique situation when it comes to implementing changes of this sort.

The Added Value of the Positive Lens

If other change/improvement methodologies could have led to similar safety innovations as the ones we achieved through Appreciative Inquiry, one may wonder what is the value afforded by using this approach.

The feeling of contribution and ownership that evolved among the staff from this intentional exercise in responsible, organizational democracy was the key. At first, there were too many initiatives to take on at once. We discussed them and together with the staff narrowed them down to five. People then knew they were part of the decision-making process. That is how you create sustainable change and buy-in. Compromise and discussion made them understand it is not "my way or the highway." People feel confident that "this is what we agreed upon." Great plans without execution are not worth much. In any hospital it is the frontline staff who deliver the care patients get. The role of leadership is important in providing the overall focus and resources, but you need the staff to execute. This "execution energy" is one of the added values from the Appreciative Inquiry approach to process redesign.

The Impact of the Positive Approach on the Leadership at Newark Beth Israel Medical Center

In order to allow teams to shine, leaders who were involved in this project now realize that they need to build on what people are good at. Now they make a concerted effort to let people use their strengths, and many managers have now become more comfortable emphasizing those strengths. For example, rather than focusing on "this e-mail is not appropriate" or "your e-mail was too abrupt," one leader now searches for "great" e-mails and uses them as examples to say that "this is an exceptional way to communicate the message. I've seen improvement and you need to continue this going forward." It is often easier for leaders to go for people's jugular, rather than highlighting what they do bring to the table. They might think this is effective coaching, but it is not.

One leader used to push everyone to participate in everything. She recently said, "I'm going to stop asking my staff to participate in external activities. I'm going to count on them to run the hospital and I'll keep doing the outside work that I am good at. I can spend all my time trying to fix or change people or I can tap their strengths." We believe people feel better going home at night knowing they have been affirmed for what they did well

along with an opportunity to grow in an area they want to develop. Managers have great choices and they need to take time out to understand them and to reflect. The patchwork quilt and the resistance to change that we create when using the deficit approach to improvement will always need more work because buy-in is just not there and it often damages rather than builds relationships.

Advice for Executives Considering the Positive Lens

First, this approach, as good as it is, will not run by itself at the start. It needs strong leadership from the top – because until staff members have experienced it, they are skeptical just like senior managers. This means you have to do your own homework to get comfortable with giving up some control.

Second, you have to believe the solutions lie within your people. If you think that outside experts or senior management are the only ones with good ideas, then this is not the route for you.

Third, a positive approach to design of organizational innovation is relatively easy to learn and succeed with, but it is not investment free. The time for people's involvement and the cost of external support the first time you try it are significant. In other words, do not use a hammer to crack an egg. Go for meaningful and measurable outcomes on things that are going to directly influence your core mission in the short run – such as patient safety and cost, rather than the things (such as culture and satisfaction) that are good but may not directly get you either the budget you need or the measurable results you seek.

CONCLUSION

We began this chapter with an acknowledgment that executives responsible for mission-critical processes in high-risk/high-stress environments are seeking change processes that take the following into account:

- Everyone is "already too busy."
- Improvement activities in "mission critical" processes must generate "immediate results and payoffs."

This case suggests that the use of an Appreciative Inquiry based positive lens for designing micro-information systems and new organizational processes can indeed respond successfully to these concerns.

The approach has the built-in flexibility needed to include all the essential voices, within the constraints inherent to situations where "everyone is already too busy." In this instance, the project not only employed a series of progressive group meetings over time – in which the key work of *Discovery, Dream, Design, and Destiny/Delivery* planning were easily accomplished – but also used off-line, one-on-one interviews to effectively tap the wisdom and energy of essential personnel who could not be made available for the group meetings. This strategy not only dealt with the situational time constraints, but also had the added advantage of generating (through the use of the appreciative interviews) the human energy needed to create the short-term results within the larger system. The approach also generated the quality and quantity of short-term results required by the project's executive sponsor.

In addition to the measurable short-term results, it is important to note that the Appreciative Inquiry based positive lens design approach generated two additional and interlinked outcomes. First, both the innovations themselves and the process used for identifying the innovations are being diffused throughout the larger hospital system. The interest generated among staff for further improvement has translated into successful implementation of the innovations within other telemetry and medical surgical units. The hospital is currently at work, spreading the innovations to the handoff from the emergency department to the perinatal and neonatal critical care units – and the plan is to use the positive lens design process for physician-to-nurse handoffs in the operating room. Second, the approach we used built internal capacity among the employees of the initial area, rather than building dependence on the external consultants. Participants in the process were not only tapped for their wisdom and improvement ideas, but also continuously coached on why each step was being taken and how each step was carried out. These two interlinked outcomes have provided the foundation for sustainability – another critical element of success in the redesign of a mission-critical process in a high-risk/high-stress environment.

Understanding the powerful dynamics of a positive organization design approach to mission-critical processes in high-risk/high-stress environments is essential if we are to more fully take advantage of this promise for change in challenging environments – and there is at least one other element that the authors believe contributed to success in this case. Paradoxically, this was the shift from focusing this project on something as soft as "culture change" to focusing it on the mission-critical process of patient transfer across departmental boundaries. We describe this as a paradoxical choice because of the widespread belief that mission-critical processes are harder to change/improve (particularly when there is no crisis, as was the case here) than

something like organizational culture. We have yet to find evidence of this widespread belief. To the contrary, our experience has been that organizational culture is something that, like the weather, everyone complains about, but very few people have much success in shifting in the short term. On the other hand, when people are invited to participate in changing their mission-critical processes in a meaningful way, there is a much higher level of resources, energy, and line leadership that emerges. In turn, this can translate into measurable short-term results, enhanced diffusion of innovation, and sustainability of the change. Whether this is because people intuitively realize that the culture will only truly shift if the core work processes are redesigned or if they simply have more energy to spend on the things that are more clearly connected to the organization's core reason for existence, is open for further exploration. We suspect it is a bit of both.

Finally, we acknowledge the limitations of drawing generalizations based on any one instance and encourage our colleagues and leaders to experiment with the Appreciative Inquiry based positive lens design approach to improving mission-critical processes in high-risk/high-stress environments. We believe that the combination of working on very important issues with an approach characterized by flexibility and a perspective that sees inquiry and change as powerfully related, seamless, and integral whole (Cooperrider & Avital, 2004) has enormous potential to accelerate the pace of change in high-consequence areas such as patient safety.

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APPENDIX A. INTERVIEW GUIDE

Interviewee Name:________________________ Interviewee Unit:__________
Interviewer Name:____________________ Date of this interview:____________

A.1. High-Point or Peak Experience

As you look over your experience with "the Beth" (NBIMC), there have been ups and downs, peaks and valleys. For the moment, please think back to one of the peaks, one of the high points – a time when you felt most alive, most engaged, or really proud to do the work you are doing here.

(a) Please tell me the story of that high point.
(b) What made it a high-point/peak experience for you?

(c) What was it *about you* and others around you that made it a peak experience? What was it about the situation, your department, the culture of the Beth, and/or the leadership of the Beth that contributed to that peak experience?

A.2. About You

If I had a conversation with people that know you the very best and I asked them, "What are the three best qualities and capabilities that <INSERT NAME of INTERVIEWEE> brings to this work?" what would they say?

A.3. Exceptional Handoffs: Emergency Department to A6 Telemetry Unit

A.3.1. The Emergency Department to A6 Telemetry Unit Handoff Process

There are a number of steps or actions required for the handoff between emergency department and A6 telemetry unit. Let us begin with your perspective of the handoff process. What would you describe as the key steps in the emergency department to A6 telemetry unit handoff process?

A.3.2. Learning from Great Times

The ultimate measure of the Beth's success is great patient care – medically, organizationally, and humanly. Our commitment to and experience with innovation and meticulous attention to patient care is a source of real learning for us.

Tell me about a specific time that you experienced the emergency department to A6 telemetry unit handoff in a way that you would describe as nearly perfect or *exceptional* – an experience that, if it had been captured on video, could serve as a teaching tool for handoffs throughout the entire Saint Barnabas System? Tell me what happened with as much detail as possible.

A.3.3. Digging Deeper

Thank you – now let us dig a little deeper. Please look at the list of questions below. What else can you tell me that will help us to understand the factors enabling exceptional handoffs?

- What was it that led you describe this experience as nearly *perfect* or *exceptional*?
- What about the report? What were the key elements of the report?

- How was the information communicated?
- What else?

A.3.4. Going to the Next Level

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 both from a patient safety/satisfaction basis and from the perspective of employee satisfaction?

A.3.5. Learning from Difficult Times

The process of handing off patients from the emergency department to the A6 telemetry unit is not perfect by any means. Sometimes our work requires us to deal with delays, bottlenecks, unanticipated problems, or other obstacles that make our jobs difficult. Fortunately, over time, we all learn about or discover tricks and other creative workarounds to help us overcome these barriers. We do this all in an effort to deliver quality care. Tell me about the tips or creative workarounds you have learned in this handoff.

A.3.6. What Would You Want?

Imagine you are away on vacation and you get a phone call telling you that a loved one is in the emergency department and is going to be admitted to the A6 telemetry unit. A colleague working in the emergency department or the A6 telemetry unit asks you what he or she can to do to support you. What would you say? What request(s) would you make?

A.4. Envisioning a Positive Future

Imagine it is one year from today and the handoff process from the emergency department to A6 telemetry unit has improved astonishingly. In fact, the Beth's handoff process has become *the* benchmark for emergency department handoffs at hospitals not only across the country but also around the world! We have got quantitative and qualitative data on patient outcomes, satisfaction, and nursing practice that demonstrate our success. Patients are singing our praises and the American Nurses Association has asked us to submit our application to the Magnet Services Recognition Program ASAP!

(a) Please describe in detail how you see the process functioning.
(b) What are we doing that is new, different, or better? What are three specific innovations, improvements, or tips we have implemented?
(c) Looking back from the perspective of a year from now, what would you tell others we did that ensured our changes occurred in a smooth and rapid fashion?

APPENDIX B. EMERGENCY DEPARTMENT/ INPATIENT UNIT WELCOME & HANDOFF SCRIPT

Unit staff: Good morning/good afternoon/good evening. My name is ________________. I am _____________ (position). I know you were in the emergency department for _____ hours. My colleagues in the emergency department work very hard to provide exceptional care to our patients. Welcome to __________ (unit name). We have been expecting you and are glad you are here now.

Emergency department staff – registered nurse/tech/orderly: (after placing patient in the bed) I am going to be leaving now. I am putting your belongings on the bedside table/in the closet. Are you comfortable? Is there anything else I can do for you? The staff of _______ (unit name) will take great care of you. Take care now.

Unit staff – registered nurse/tech/nursing assistant: Hello, my name is _______________ and I am _________ (position). This is Room # _____. I want to review some information and orient you. (Staff will inform patient on the following: phone and television service, visiting hours, meal times, bathroom, call bell, and bed control and telemetry monitoring.) Is there anything else I can do for you? (If the registered nurse caring for the patient is present, inform patient on the plan of care.)

APPENDIX C. STANDARDIZED TRANSFER REPORT

With permission from NBIMC, an affiliate of the Saint Barnabas Health Care System.

STANDARDIZED TRANSFER REPORT

Gender: ☐ Male ☐ Female Bed Assignment______ Admitting Date/Time______

DX=______ Doctor______ Consults______

PMHX=______

Allergies______

V/S Prior to Transport BP______ P______ R______ Temp______ SpO_2______ Pain Scale______ Weight______

Mental Status: ☐ Alert ☐ Awake ☐ Oriented x4 ☐ Person ☐ Place ☐ Time ☐ Events ☐ Ambulatory

Safety Triggers: ☐ Fall Prevention Protocol ☐ N/A Isolation ☐ No ☐ Yes______

Restraint ☐ No ☐ Yes One-to-One ☐ No ☐ Yes Line of Sight ☐ No ☐ Yes Q15 min check ☐ No ☐ Yes

DIET
Nutrition Consult: ☐ Done ☐ Pending
NO ☐ Diet______

SKIN
☐ Intact ☐ Stage______
Wound Location______

ACTIVITY
☐ Bedrest ☐ Other______

CARDIOVASCULAR
Heart Rhythm______
Intubated: ☐ Yes ☐ No
Date______
Vent Setting: TV______ FIO_2______
RR______ PEEP______
O_2 Therapy______ Resp. TX: ☐ Yes ☐ No
Time: ______

MEDICATIONS
☐ See MAR

SUMMARY OF ED STAY/FOLLOW-UP CARE
______
______

LABS
Significant Labs______
______
______

CARDIAC ENZYMES
1. Date______ Time______ ☐ +ve ☐ -ve
2. Date______ Time______ ☐ +ve ☐ -ve
3. Date______ Time______ ☐ +ve ☐ -ve

IV ACCESS **Drip Conc Rate**
Type/Size/Site 1______
Type/Size/Site 2______
Type/Size/Site 3______
Blood Transfusion: ☐ Yes ☐ No ☐ N/A
Blood Transfusion Consent: ☐ Yes ☐ No ☐ N/A
Blood Product______

PROCEDURES COMPLETED
X-Ray______ Result______
CT Scan______ Result______
Echo ______ Result______
Doppler______ Result______
Ultrasound______ Other______

BELONGINGS
☐ Patient ☐ Family ☐ Security
Dentures ☐ Yes ☐ No
Eyeglasses ☐ Yes ☐ No

TRANSPORT
Low Risk Cardiac Transport Protocol ☐ Yes ☐ No
(If NO, patient must be transported with monitor)
Monitor ☐ Yes ☐ No ☐ N/A
Nurse ☐ Yes ☐ No ☐ N/A
Oxygen ☐ Yes ☐ No

ED RN PRINT______

FAX/REPORT TIME SENT______

UNIT RN NOTIFIED ______

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