# Working THROUGH the workaround:
## FIX why your nurses can't adopt new HIT and STOP why they won't

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## Introduction

Process and technology workarounds exact a cost to the healthcare system and the nurse leader in terms of risking patient safety, stressing management and staff team relations, and delaying or stopping adoption of high-cost technology and system-wide program implementations that fall under nursing purview and sometimes the nursing budget. This poster will provide clear guidance for the nurse leader to proactively and practically address and resolve these issues.

## Objectives

At the conclusion of this presentation you will be able to:

1. Apply evidence-based error and change theory principles in practically approaching and resolving the workaround issue

2. Describe authentic communication techniques, including correct phrasing of probing questions to determine workaround cause, that will engage the nursing team and support effective management of group process as well as the individual informal and influencing leaders

3. Integrate human factor planning in managing nurse to nurse (human) variability from a system perspective in order to prevent future workarounds

## Abstract

The workaround plagues all new processes in addition to derailing adoption and potentially wasting hundreds of thousands, if not millions, of HIT dollars, when workarounds are created for BCMA, EHR documentation, and specimen and transfusion management, patient safety is jeopardized, and nursing care excellence is wounded. Even in just cultures of safety, organizations are turning to punitive methods to avert this crisis, and yet the workaround continues. As high reliability organizations, healthcare organizations can no longer tolerate the lack of compliance that workarounds represent; as nurse leaders we have to trust that workarounds are not indicative of a lack of commitment. Building upon the premise that the nurse faced with new technology and process requirements is committed to doing the right things well for safe patient care, five factors for successfully defusing the acute and chronic workaround will be presented:

1. The application of error and change theory principles in practically approaching and resolving the workaround issue

2. Establishing the need for a system (v. person) approach at the healthcare "sharp end of the stick"

3. Authentic communication techniques, including correct phrasing of probing questions to engage the nursing team and manage group process as well as the individual informal and influencing leaders

4. Human factor planning in managing human variability from a system

5. Workaround prevention in a culture that is both safe and just

## Questions for the nurse leader

**Questions to ask of the system:**
- ☑ Where are the workarounds in your current system? Have they become the system?
- ☑ Are workarounds tolerated in some instances and not others? Does – or has – leadership become blind to the "needed" workarounds?
- ☑ Why are they tolerated/allowed to continue?

**Questions to ask of yourself:**
- ☑ Are you willing to commit to a Workaround Free Zone (WFZ) throughout the system?
- ☑ Will you be the voice – and action – of leadership in a just culture of safety for everyone in the WFZ?
- ☑ What's your timeline? The optimal time to fix the workaround issue is before it starts – before implementation and definitely before purchase

**Questions to start planning now:**
- ☐ Do you know what HIT is being considered now and in future budget cycles that will be used by your nurses?
  Invite yourself into the conversation with Pharmacy (BCMA) – IS (EMR) – Lab (Specimen Collection) – Blood Bank (Transfusion Management) – CMIO/CIO/CEO



How does *this* 3 step process

turn into **THIS?**

And eventually to **THIS??**

**Is it time for a Red Rule?**

## Guidance from the literature: Human Error Theory and Resolution

### Are nurses just BAD?

Two approaches to the problem of human fallibility exist: the person and the system approaches

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness

The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects (Reason, 2000, p. 768).

### Root Cause Analysis and the Workaround

1. Provides system evaluation rather than personal

2. Offers objective process with clear goal

First-order problem solving behavior occurs when the worker compensates for a problem by getting the supplies or information needed to finish a task that was blocked or interrupted. The worker does not address underlying causes, thus not reducing the recurrence of a similar problem in the future (Tucker & Edmondson, 2003, p. 60).

Any event can have multiple root causes, and breaking the chain of events anywhere in the line "can avoid the final breakdown" (Burkhardt, et al, 2007). Keeping this goal in mind, the RCA is designed to identify both active errors (errors occurring at the point of interface between humans and a complex system) and latent errors (the hidden problems within health care systems that contribute to adverse events) (Agency for Healthcare Research and Quality, 2010). In addition the RCA is used to reflect, "…on what it reveals about the gaps and inadequacies in the healthcare system", which includes the people and, "…how they communicate, interact, work as a team, and work together to create a safe organization" (Taylor-Adams & Vincent).

"What happened, why it happened, and what can be done to prevent it from happening again?"(Wu, Lipshutz, & Pronovost, 2008).

Some workarounds are actually attempts to protect patients and promote care excellence, and must be evaluated! Nurses should not be punished for their attempts to improve a process, but must be encouraged to participate in system-wide solutions (Lally & Malloch, 2010) .

## Communicating Authentically - and Effectively - as the Nurse Leader

**Authentic Communication for the Nurse Leader**

How can a nurse leader consistently communicate authentically? Authentic communication flows from authentic leadership.

"Authentic leaders confess to fact or speak the truth and therefore are worthy of trust, reliance, or belief" (Henry 2006, p. 265).

By establishing a just culture of safety within, the nursing leader establishes communication that flows in both directions, and nurses are assured of the safety in "speaking truth to power".

- ✓ Use "CLEAN LANGUAGE" (Green, Bren)
- ✓ Develop rapport
- ✓ Listen respectfully – allow the nurse to complete thoughts without interrupting

Questions to ask the nurse who persists in working around the HIT – you can use these in a group as well

1. What kind of _____ is that? (Green, Bren)
   "won't" - this demonstrates you are not prejudging and have not already come to a conclusion
   LISTEN CAREFULLY FOR SPECIFIC WORDS, AND USE THOSE WORDS IN YOUR NEXT QUESTION

2. What kind of _____ is that? (Green, Bren)
   - LISTEN WITHOUT COMMENTING
   - BE CALM
   - STOP INTERNAL CHATTER BY PUTTING YOUR TONGUE TO THE ROOF OF YOUR MOUTH, SO YOU CAN REALLY LISTEN
   - WHEN THEY FINISH, WAIT AT LEAST 8 SECONDS……AND THEY WILL USUALLY CONTINUE TALKING

3. Is there anything else about _____ ?
   CONTINUE TO ASK CLARIFYING QUESTIONS IN THIS WAY UNTIL YOU HAVE THE INFORMATION YOU NEED TO PROCEED

At this point, you can evaluate if this is an issue of can't versus won't.

Since you have developed rapport and open communication, you can then

- Restate the nurse's feedback to ensure you have received the entire message and understand
- Always ask "Is there more?"
- State clearly and objectively the necessity for following the policy if it will remain unchanged
- If the policy is open to change, ask the nurse for help and commitment to change the process in this way, you may develop one of your strongest advocates
- If you are working with a group, observe for the individual who "won't" and who has the most influence – this may be the person to reach out to for aligning organizational and nursing needs

**What if…?**

If a nurse emphatically will NOT follow direction, protocols, practice, without a contributory reason – simply "doesn't want to" – this is unsafe and insubordinate, and the person should not be permitted to return to patient care without counseling/coaching/remedial process – or permanently relieved of duties. As the nurse leader, you must evaluate each situation and make the appropriate decision that meets organization and legal standards.

"Nurses have been found to be willing to embrace safe patient handling and other technologies if they are convenient; easy to use; target a high-risk, high-cost, and high-prevalence problem (such as falls); and are either compatible with existing work patterns or have the potential for improving efficiency and time spent with patients. It is likely that nurse characteristics that influence the use of technology are specific to the technology in question. For example, in a study of implementation of a nursing documentation information technology system, the investigators found that adoption was influenced by a number of attributes of the nurses, including commitment to nursing care planning and written documentation, acceptance of computers in nursing, computer and typing skills, professional experience, level of motivation, and climate of trust and support within the nursing team" (Powell-Cope, Nelson & Patterson, 2008, pp. 3-211).

## Human Factors Engineering Analysis

This is an actual HFE analysis of an ED workflow; trauma workflow was analyzed separately. Note that observation and interviews are necessary to determine accurate workflow; patient care takes precedence in any observation. Process unknowns, failures, opportunities for improvement, and workaround potentials are surfaced in this exercise, and must be resolved proactively.



Emergency Room Nurse Persona Work Model – emergent, non-trauma:

## Practical Application



## Conclusion - What you as the nurse leader can do now to work THROUGH the workaround

**To FIX why your nurse leaders *can't* adopt, the nurse leader must address multiple issues and stakeholders**

- ✓ Start by asking questions – of everyone involved, particularly the nurse end-user: *What else in the process is stopping you?*
- ✓ Observe the process
- ✓ Listen to your staff – engage them in solutions
- ✓ Talk to related departments and other stakeholders
- ✓ Conduct a FMEA before implementation/RCA after for workaround events
- ✓ Know the process AND the best argument
- ✓ Involve vendors – get commitment to fix or retrain when necessary
- ✓ Identify the most influential users – invite them to participate
- ✓ Be ready to revisit the issue (over and over again) – if it will not be changed
- ✓ Be credible, flexible, and committed to safety: for organization, patients, and staff

**STOP ANY UNSAFE AND WILLFUL RISKING OF PATIENT AND ORGANIZATION**

**Walk the talk of a transformational leader in a just culture of safety.**

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