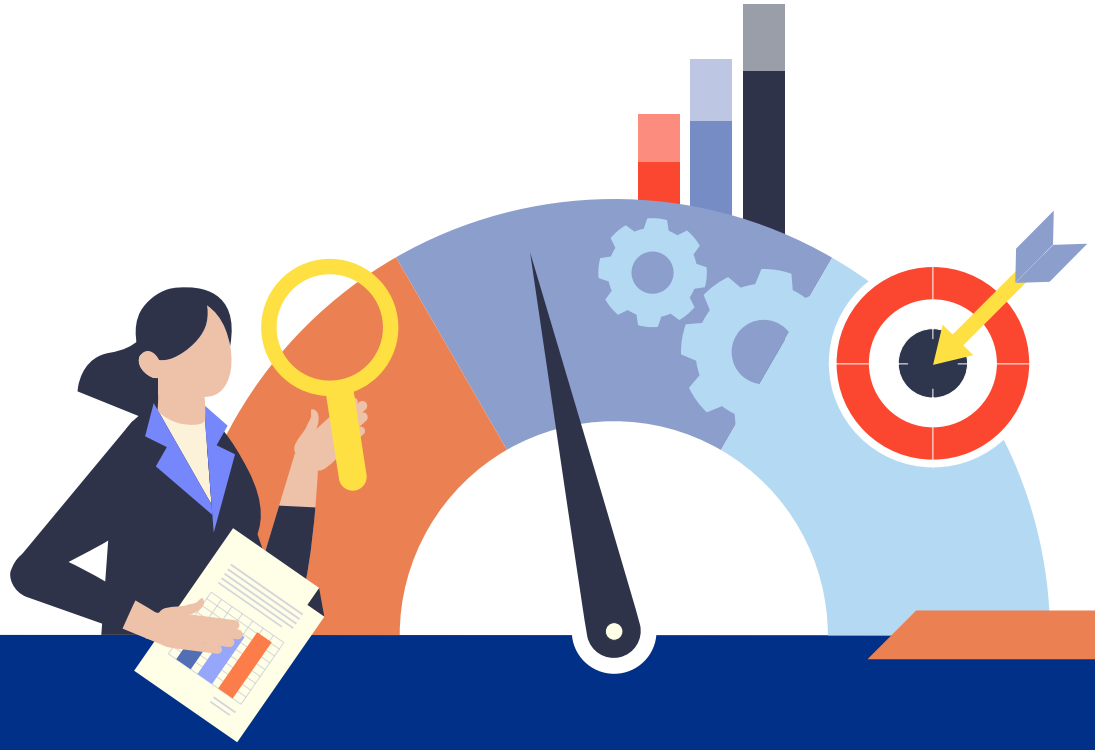

Building a Culture of Quality: Driving Outcomes Across the Organization

How nurse leaders can sustain quality initiatives

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Nurse leaders today face competing demands in quality improvement: mounting pressure to meet evolving regulatory reporting requirements, growing expectations to demonstrate return on investment, and the challenge of sustaining consistent practices across units with different patient populations and workflows.

In this executive dialogue, nurse leaders explain how they identify leading indicators that reliably predict quality outcomes, build consistent practices across units, and connect harm reduction, length of stay and readmissions to measurable return on investment.

KEY TAKEAWAYS

1. Bringing front-line staff into quality initiatives from the start and removing barriers to compliance leads to stronger results than simply relying on mandatory education modules or top-down directives.
2. Multidisciplinary ownership matters. Rebrand initiatives as team efforts to help physicians, pharmacists, therapists and others see their role in quality outcomes.
3. Nurse leaders can make a credible financial case by quantifying the cost of harm events, projecting reductions and tying readmissions to breakdowns in process rather than patient behavior.
4. Nurse leaders who give front-line staff a voice at the system level, share best practices across sites and build clear escalation paths are better positioned to sustain quality gains organizationwide.

Building a Culture of Quality: Driving Outcomes Across the Organization

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MODERATOR: Terese Thrall *(American Organization for Nursing Leadership):* **What processes are you using to implement quality initiatives?**

Jeannie Berry *(CHRISTUS Santa Rosa Healthcare):* Our system uses HAI dashboards to track infections such as CAUTI, CLABSI, C. difficile and surgical site infections, with clear targets for each facility.

Our system and facility nursing leaders have developed playbooks for sepsis and infection prevention that we share with bedside nurses. These standardize what to monitor and how to follow prevention bundles.

As a regional CNO, I round daily with our executive team, including quality, infection prevention and nursing leaders, to help staff understand the "why" behind the work and how their daily practice connects to outcomes. We split across units each day and use that time to address specific practices.

Maureen Sintich *(Inova Health System):* We use the 4DX methodology, or the four disciplines of execution, to focus on a small number of priority goals. We apply that approach to CAUTI, CLABSI and other HAIs, but the work happens at the unit level. Teams decide how they will implement the bundle. They own the work, track their progress and continue working to bring rates down.

Each unit identifies a goal based on the parts of the bundle they are struggling with and tracks it. Teams take ownership of that goal at the unit level through their professional governance councils. We set guardrails so teams cannot change the bundle itself, but they can identify which parts of the bundle they are struggling with and make that their focus.

Teams talk about their goal every day in huddles. That keeps the work visible and part of their routine. It is not a separate project layered on top of their work.

Different units focus on different priorities. Teams also partner with physician leaders and other members of professional services.

Christin Gordanier *(UW Medicine/Northwest Hospital & Medical Center):* We spend time with teams to understand what is making it hard to follow best practices. Then we fix those barriers and put specific changes in place. The goal is to make it easy for staff to consistently do what we know is the correct, evidence-based care.

Medline's SmartStep central line dressing kit is a good example. It guides you through each step of the dressing change, so you don't break your sterile field.

> "Nurses already carry a heavy education burden, and assigning more courses is not helpful on its own. What works is helping people understand the "why" and making it easy to do the right thing."
>
> *Stacy Jemtrud*
> *Orlando Health St. Cloud Hospital*

Our campus serves a largely geriatric population and we had a serious falls problem. Fall mats were underused because they are heavy, bulky and difficult to move equipment over. We tested and then implemented a fall mat built into the furniture on either side of the bed. It does not move, equipment rolls over it easily, and staff can use it without added effort.

We saw a significant reduction in falls leading to injury and there wasn't much of a barrier to compliance.

Genteal Pelzer *(Advocate Aurora Health):* We are moving away from the term "nursing-sensitive indicators." Many disciplines are involved in these outcomes, and when we label them as nursing, other partners may not feel the same level of ownership. We have started referring to them as patient-sensitive or clinical team-sensitive indicators and engaging all disciplines in that work.

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When we review an event, we invite every discipline that touched the patient. That includes the nurse and CNA who provided care, as well as physicians, pharmacy, therapy and others who may offer a different perspective. Early on, physicians were not invited to some of these reviews, even when they were involved in the care. We have worked to bring those voices to the table.

For falls, we hold drill-downs within 48 hours. We ask the bedside team to walk through what happened, and we also ask what more we could have done to support them.

We take the same approach with other events, including codes, HAPIs and surgical site infections.

We also challenge our quality team to think proactively. What could have been identified earlier? Could monitoring or auditing have surfaced a risk before the event? Could reviewing the dashboard have helped leaders focus their rounding or follow up on care that was missed?

Barbara Prior *(Clinical Practices of the Hospital of the University of Pennsylvania):* Our overall fall rate is relatively low, but falls with injury kept occurring, so that became a major focus.

We developed an education video for all front-line staff to reinforce that this is a whole care team effort. In the exam room, the provider is often the last person with the patient, so we are working to ensure they stay until the patient is safely off the exam table. We also purchased lower exam tables to better support patients with limited mobility.

We also have a falls collaborative that looks at fall rates across the system. Work is started in inpatient settings by looking at evidence-based assessment tools, with the goal of applying what works more broadly.

We found some unexpected issues. Patients wearing certain sneakers were having trouble with traction on the floor. That led us to work with environmental services to adjust floor care.

We expanded our screening questions in the electronic medical record. In addition to asking whether a patient has fallen recently, we now ask about assistive device use. We are also working to provide education before the visit and are in the process of measuring whether that makes a difference.

We conduct root cause analyses on falls with injury and try to scale what we learn. Our falls-with-injury rate is coming down.

At the system level, our CNOs and chief medical officers (CMOs) meet every other week to review quality indicators, share best practices and learn from one another. That has been valuable. Quality is part of Penn Medicine's team goals.

Peta-Ann Anderson *(Jackson North Medical Center):* Our quality coffee club has made the biggest difference. Staff collaborate together, then take that

information back to their units and share it with peers. We have had one infection over the past two years and moved from a C to a B hospital rating. I give that credit to staff engagement and alignment. We do morning huddles where nurses report on every line and catheter, including why it is in place and how long it has been there.

Stacy Jemtrud *(Orlando Health St. Cloud Hospital):* We have moved away from relying on mandatory education modules. Nurses already carry a heavy education burden and assigning more courses is not helpful on its own. What works is helping people understand the "why" and making it easy to do the right thing. Staff want to do the right thing, and they need the right tools and resources to support that.

Berry: We stepped back from electronic education assignments. At one point, a single group of nurses had 150 assigned modules because every incident triggered a new course. We shifted to in-person, in-the-moment education. That might be a two-minute huddle, infection prevention staff coming to the unit or clinical directors reviewing material directly with their teams.

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>
> *Maureen Sintich*
> *Inova Health System*

We have also seen strong results from weekly falls debriefs. When a patient falls, we bring everyone involved together that week, including the nurse, certified nursing assistant, physician, sitter and transporter. It is a safe space where front-line staff can talk through what did and did not work.

We use the same approach for codes and CLABSIs. One thing we learned is that physicians do not always understand how these events are counted. A Foley can be removed and reordered within 24 hours and still count as a CAUTI. The same applies to central lines and cultures. We worked with physician teams to walk through how these metrics are defined. Now, culture orders must be discussed with and approved by the attending before they are placed.

Sintich: If a problem is not rooted in a knowledge gap, education will not fix it. You have to identify the root cause and apply the right intervention. Along those lines, we have used the implementation science methodology and de-implemented bed and chair alarms across eight departments with expansion to five additional units in process. There is no evidence that they prevent falls. As they are designed today, the alarm sounds after the patient is already out of bed, or if too sensitive will cause alarm fatigue.

We have seen reduced alarm fatigue, improved patient satisfaction, more purposeful rounding and a decrease in both falls and falls with injury. It is a difficult cultural shift, because nurses are understandably concerned about removing something that feels protective, but the evidence supports it.

Kellie Garth Green *(UW Medical Center):* We have reinvigorated dyad partnerships between unit medical directors and nurse managers. When a CLABSI or CAUTI occurs, the quality medical director reaches out to the provider to understand why the line was still in place and what the clinical indication was.

We also changed how we round. Historically, we focused on nurses. Now we round with residents and ask them directly about nurse-driven protocols. Many do not know them, which creates a gap.

We also found that nurses were hesitant to act on those protocols without calling for an order. We have worked to change that by making it clear that the nurse at the bedside has the authority to remove a catheter when appropriate.

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The dyad partnership brings both sides into the work. We have seen reductions in central line and catheter metrics, even in high-volume oncology settings where many lines are medically necessary.

MODERATOR: Are there units or service lines where you have system-level standardization, and where you allow local adaptation without compromising outcomes?

Sarah Buenaventura *(Northwestern Memorial Hospital):* We recently revamped our committee structure. We now have the CMO, the CNE and director- and vice president-level support for each quality indicator, along with a team-of-teams approach that brings quality leaders and infection prevention together.

We are setting high goals, but we are thinking about what is realistic over two years and reporting on progress every week with leaders, medical directors and physicians in the room. This work is no longer driven by nursing alone. Vice presidents and directors are now presenting outcomes.

We have seen a decrease in CLABSIs. We are looking closely at the barriers and what we can impact on the nursing practice side, whether that is CHG bathing, line maintenance or insertion.

Victoria Varsho *(Sanford Health Marshfield Clinic):* We take a data-driven and unit-specific approach when implementing quality initiatives.
We introduced an oxidative to reduce C. difficile infections and saw a significant decrease in rates across most units. However, in our neonatal ICU, staff identified concerns related to the odor and outcome data did not demonstrate the same level of benefit. After reviewing both the data and front-line feedback, we made the decision not to implement the cleaner in that unit. This reinforced the importance of balancing standardization with local context and continuously monitoring outcomes to guide decisions.

Berry: Every service line is unique. In our neuro service line, patients who have had flaps or elevated intracranial pressure may need a Foley catheter longer than standard protocols recommend. That means the team needs to recognize when care differs from the usual approach, understand why and monitor those patients more closely, since the risk of infection is higher. Infection preventionists also monitor these cases.

MODERATOR: What are the essential leading indicators that nurse leaders need to review weekly to steer nursing workflow?

Vi-Anne Antrum *(Cone Health):* We look at bundle compliance and mobility rates. We use dash-boards, go to the units to observe what is actually happening. We also use visual management boards to monitor those measures.

We track left-without-completing-care rates. From the time an admission order is placed in the emergency department, we try to move patients to an inpatient unit within 20 minutes. It is an aggressive goal, but it helps focus the work.

We have a unified message from the front line all the way up to leadership and back down. That is where things can go awry, when different people are saying different things. We also track nursing engagement.

We have a strong team of clinical nurse specialists, educators and professional development specialists who help ensure we are using the most up-to-date evidence and spreading it across the system. We bring together quality, infection prevention, nursing, pharmacy, physicians and care managers around a shared goal.

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Prior: Falls, medication safety, diagnostic errors and specimen collection are our key safety indicators right now. These are team goals set from the top and owned at every level, and that has helped improve our metrics and drive outcomes.

On the ambulatory nursing-sensitive indicator side, we are still developing that framework. Examples include blood pressure control and colorectal screening. We follow quality and safety through an equity lens.

Anderson: Nurse leaders on a daily basis validate that bundles are being completed through a single platform. During rounding, they are checking lines, reviewing Foley use, talking with the patient and making sure needs are met. That feeds into patient experience data and gives us compliance data we can track.

We are at about 80% compliance now, and we started about a year ago. Having a platform that allows us to monitor compliance and give feedback to leaders has been a real shift. We also track hand hygiene, and because workplace violence has increased, we now review weekly reports on incidents by location. We found that many were happening in the emergency department, so we made changes there.

> "Health care is a team sport and people need to feel that they are part of it."
>
> *Stacy Jemtrud*
> *Orlando Health St. Cloud Hospital*

Jemtrud: Marking milestones matters. We recently celebrated more than a year with no hospital-acquired infections, and we celebrated the whole team, not just nursing. Health care is a team sport, and people need to feel that they are part of it.

MODERATOR: How are you assessing return on investment (ROI) so you can get buy-in from operations and finance?

Prior: Our health system has adopted quality as our North Star, using a quality and accountability dashboard, and the hospitals have really embraced it. On the ambulatory side, we are newer to that work, but we recently brought operations into it alongside quality so that more people own the indicators that drive change to improve patient outcomes.

Green: I think that is exactly the key. If you are saying "this is our North Star," then you have to put FTEs behind it.

We started a trial with clinical excellence coordinators. We pulled two bedside nurses into this role to support the areas that have the highest number of central lines. These coordinators go to each unit, talk to nurses and observe what is actually happening with central line care in patient rooms.

What they observed was different from what nurses reported. A nurse might say she is scrubbing the hub, and she is, but when you observe it, it may be for 15 seconds instead of 30 for example. These coordinators then worked with their peers on competencies, going through dressing changes together and having real conversations about central line care.

It is still a trial. But you have to look at the return on investment and what you are facing in penalties for these events.

Berry: There is a real financial ROI there. I am not sure I can always get additional FTEs approved, so we build accountability into what we already have.

We start with the 7 a.m. bedside shift report, where nurses hold each other accountable. We observe those reports to make sure they are actually happening. When I round at 8:30 and something is missing, I ask directly what happened during that handoff.

We have also focused on supplies and equipment. Education without the right tools only goes so far. For HAPIs, we had wedges available, but nurses were using pillows instead. We brought in our vendor for two weeks across multiple shifts to train staff on how to use wedges and apply boots correctly.

We were seeing deep vein thrombosis because the pneumatic tubing was not being threaded correctly through the boot. Once we corrected that, our numbers dropped. We had a high number of stage three pressure injuries and have not had one in six months. Now we are focusing on stage twos, which will become reportable in 2027.

When I go to operations or finance, I can show what we did, what it cost and the financial benefit.

Sintich: Our executive structure supports a more evidence-based and methodical approach. Myself, our chief clinical enterprise officer (physician executive), our chief clinical enterprise operations officer (administrative executive) and our chief financial officer meet together weekly for at least two hours.

Our finance colleagues also round in care sites and go to the units to observe what is happening. That way, when questions come up, they already have context.

Anderson: Sometimes when I present a project to leadership, I cannot always give a definitive dollar amount. I frame it as a patient safety initiative to improve outcomes. At the end of the day, our mission is to provide a safe, quality standard of care.

Some returns come later. For example, we implemented telehealth in the emergency department so patients in the waiting room can start with a physician assistant instead of waiting. I could not show an immediate financial return at the time, but I framed it in terms of improved access, patient experience and the downstream revenue that comes from more timely care.

Antrum: You can estimate the impact and assign dollars to it when building the business case. We are treating every readmission as a failure of our process.

We are interviewing every patient who returns to understand why, and we are finding that social determinants of health are often the primary drivers. On the ambulatory side, we are looking at access to appointments, wait times, care management and transitions of care.

We did need to add resources, but I went to leadership with a clear case. We projected $1.1 million in reductions based on diagnosis-related groups and our Medicare population, with additional impact across other payers.

I also requested 35 FTEs to embed case management in our emergency departments. Alongside that, I identified nearly $10 million in reductions in the budget. That allowed leadership to approve the request.

MODERATOR: **How do you scale successful practices and initiatives?**

Buenaventura: We are working on an escalation algorithm. What happens when a patient refuses a medication or refuses to be turned because of pain?

If I am the nurse and the patient says no, I can escalate to the charge nurse. If that does not work, it goes to the clinical coordinator, and then we involve the provider to help have that conversation with the patient and family.

We are looking at how to apply that approach consistently across different metrics. Some experienced nurses do not always think to escalate. In some cases, it is about respecting patient autonomy. In others, it is about not having time to come back and try again later.

Berry: We use shared governance at the local level, but we have also built it out at the system level through service line meetings. Each month,

> "... the key components of a successful quality initiative come down to driving accountability, ensuring front-line staff have the right tools and resources, and maintaining engagement across the organization."
>
> *Katie Treptow*
> *Medline*

a representative from each service line at each hospital across our ministries joins a call. We have committees for areas like trauma and critical care, each with executive sponsors.

Attendees may include educators, clinical directors or bedside nurses. They bring best practices from their own facilities to the system level. Solutions move up to the system and then flow back down to other sites.

We also hold staffing effectiveness meetings. We review metrics and connect any quality issues to staffing concerns in the same conversation.

Varsho: We've established a strong structure for sharing and scaling best practices. Each month, we hold a system-wide quality cabinet meeting where individual sites present case studies highlighting successful initiatives. These presentations, led by the CNO and CMO but grounded in work from the local teams, allow us to learn from one another and intentionally spread what's working to other hospitals.

In addition, our nurse executive council meets weekly across the system. This forum allows us to work through operational details, align priorities and identify opportunities to standardize initiatives while still respecting site-level differences.

MODERATOR: What are the most important elements in successfully implementing a quality initiative?

Pelzer: Ensuring team engagement and including the front line in the initiative and its rollout. And having a process to actually observe what you are expecting. If you do not inspect what you expect, initiatives fail quickly.

Buenaventura: Lead with the language of what is best for the patient. If you start there, everything else makes sense.

Berry: Before implementing anything new, go to the bedside nurses, get their feedback and make sure they have buy-in. Is it going to interrupt their workflow? Is it going to add time? It is important to go to the source before doing anything.

Anderson: Make sure the whole team is aligned from the start.

Pelzer: A staff nurse recently told me he wanted to understand the actual cost of falls and how that impacts the bottom line, including whether it affects raises or merit-based pay. That was a good reminder that financial impact resonates for some people in a way that clinical framing alone does not.

Katie Treptow *(Medline):* From what we hear consistently from health systems, the key components of a successful quality initiative come down to driving accountability, ensuring front-line staff have the right tools and resources and maintaining engagement across the organization.

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