



Always Events[®] Toolkit

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Background

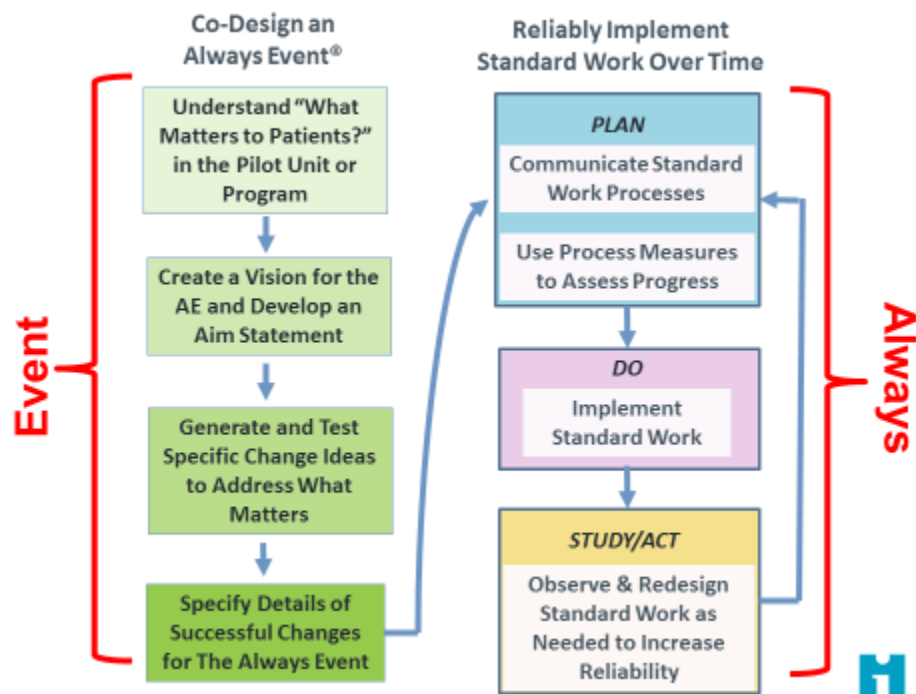
Clinicians and staff in all clinical settings seek to understand and provide compassionate care to meet the comprehensive needs, values, and preferences of the people they serve. Yet, in the busy world of clinical care, all too often what really matters to patients, their family members or other care partners, and service users is not understood or adequately addressed. The Institute for Healthcare Improvement (IHI), Picker Europe, and NHS England developed a program to test IHI's Always Events Framework and create guidelines and a toolkit for implementing Always Events®. Between February 2015 and April 2016, the program engaged 10 provider pilot sites across England to evaluate implementation of Always Events and assess the impact on improving health care quality in these settings. This version of the toolkit is based on a full years' work with Always Events in the selected NHS England Trusts listed in [Appendix A](#).

All organizations have varying degrees of comfort and experience in partnering with patients, family members or other care partners, and service users in quality improvement. This toolkit can be adapted to fit an organization's experience and context.

What Are Always Events?

Always Events®, initially conceived in the US by the [Picker Institute](#) and now led by the Institute for Healthcare Improvement (IHI), are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system. IHI's Always Events Framework (see Figure 1) provides a strategy to help health care providers — in partnership with patients, care partners, and service users — to identify, develop, and achieve reliability in person- and family-centered care delivery processes.

Figure 1. IHI's Always Events Framework



An Always Event is a clear, action-oriented, and pervasive practice or set of behaviors that:

- Provides a foundation for partnering with patients, their care partners, and service users;
- Ensures optimal patient experience and improved outcomes;
- Serves as a unifying force for all that demonstrates an ongoing commitment to person- and family-centered care; and
- Adds meaning to the work of care team staff.

The US-based National Quality Forum’s [Serious Reportable Events](#) in health care are often referred to as “never events.” NHS England has compiled data and created a policy and guidelines around [Never Events](#). Few would disagree that incidents such as performing surgery on the wrong site or a death caused by a medication error are not only tragic and harmful, but also that such events should never happen. Conversely, there are care processes and behaviors that should always occur – for example, reliable implementation of evidence-based care and the adoption of professional standards of practice – to ensure safe, high-quality care.

A key distinction of an Always Event is that patients, their care partners, and service users have identified the event as fundamental to improving the experience of care. A fundamental principle in co-designing Always Events is to move from “doing *for* patients” to “doing *with* patients” (see Table 1).

Table 1. A Comparison of What Always Events Are, and Are Not

Always Events are...	Always Events are not...
Reliable processes or behaviors that ensure optimal patient, care partner, and service user experiences of care	Evidence-based practices (e.g., handwashing) or professional standards of practice (e.g., patients are treated with dignity and respect) that should “always” occur to ensure safe, high-quality care
Co-designed with patients, care partners, and service users (done “with”)	Improvement in processes that are done “for” patients and family members
Integrated into overall person-centered care strategies	An isolated organizational QI initiative or local improvement (“flavor of the month”)

Always Events are aspects of the patient experience that are so important to patients, care partners, and service users that health care providers must aim to perform them consistently for every individual, every time. An Always Event must meet four criteria:

1. **Important:** Patients, their family members or other care partners, and service users have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented.
2. **Evidence-based:** The event is known to contribute to the optimal care of and respect for patients, care partners, and service users (either through research or quality improvement measurement over time).
3. **Measurable:** The event is specific enough that it is possible to determine whether or not the process or behaviors occur reliably. This requirement is necessary to ensure that Always Events are quantifiable and not merely aspirational.

4. **Affordable and Sustainable:** The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organizations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.

[IHI's Always Events Framework](#) holds promise as an approach to accelerate improvement efforts to enhance experiences of care with patients, their family members or other care partners, and service users. Genuine partnerships between patients, service users, care partners, and clinicians are the foundation for co-designing and implementing reliable care processes that hold promise for transforming care experiences. The goal of these processes is an “Always Experience.” The creation of an Always Event is a practical methodology for achieving this goal.

Purpose of the Always Events Toolkit

Based on the growing body of evidence and IHI's experience to date in co-designing and implementing Always Events, [IHI's Always Events Framework](#) is a practical approach for providing positive experiences of care. This Always Events Toolkit is designed to support leaders and point-of-care teams in partnering with patients/individuals and family members to co-design, reliably implement, and spread care processes to dramatically improve care experiences for patients/individuals and family members. The toolkit provides guidance on four distinct phases for co-designing Always Events (see Figure 2).

Figure 2. Four Phases for Co-designing Always Events



1. **Set-up and Oversight of Always Events**, including engaging leaders, convening an oversight team, identifying the highest-leverage opportunities for improvement, selecting a pilot unit, and recruiting a point-of-care team for the work.
2. **Co-design and Test an Always Event**, including a point-of-care improvement team of clinicians, staff, patients, and family members collaborating to co-design meaningful process improvements, testing the components and composite of the Always Event.
3. **Reliably Implement an Always Event** by leveraging reliability science to make the tested process happen for every patient, every time.
4. **Sustain and Spread Always Events**, including ensuring successful Always Events are sustained and spread to additional areas of the organization.

Set-up and Oversight of Always Events

With more than 25 years of experience working with health care teams, IHI has found that successful improvement efforts start with deliberate planning and preparation. Always Events

improvement efforts are no exception. We suggest that teams complete the following steps to get started on their Always Events efforts (described in more detail below):

- Convene an oversight team, including the identification of an executive leader.
- Identify opportunities for improvement that align with your organizational strategy.
- Select a pilot unit, clinical program, or population to co-design Always Events to address opportunities for improvement.
- Recruit a point-of-care improvement team for the pilot work.

Engage Leaders

Leadership Checklist

- Set a positive tone
- Maintain clarity of purpose
- Communicate and engage people across the organization
- Create and maintain focus
- Reinforce a culture of continuous improvement and learning

To be successful at implementing an Always Events initiative, organizational leaders must define the purpose of the initiative for their organization and model the desired behaviors. Leaders need to set the right tone for creating an Always Event, positioning the initiative as a positive way to enhance both the patient and staff experience rather than one more “flavor of the month” project. Effective leaders communicate the vision for Always Events during all four phases of the Always Events process (see Figure 2).

The framing of an Always Events initiative by leaders is essential for success. Without this clarity of purpose, organizations may pursue a variety of well-intentioned actions that fail to achieve positive patient experiences on a consistent basis. Instead, what results are “random acts of goodness.”

Ongoing information sharing about the Always Events initiative to all stakeholders should be part of all regular venues for communication. Sharing impactful results through storytelling is particularly effective. It is important for staff and clinicians across the organization to understand what the Always Events initiative is; how it will improve the care experience for patients, care partners, and service users; and how they can contribute. Early engagement across an organization will also facilitate efforts to scale up the Always Events initiative beyond the pilot setting to the larger organization.

Leaders need to ensure that the organization selects an area of focus for an Always Events initiative that is realistically designed and capable of being achieved within a defined time period. Improving comprehensive person-centered care can seem overwhelming if the issue is not broken down into achievable components. Carefully defining the scope and scale of an Always Event, as well as defining measures of success, helps keep the initiative from becoming too broad and diffuse to have an impact.

During implementation, leaders are essential in sustaining the focus and commitment to the initiative, providing the necessary resources and aligning the initiative with other organizational priorities. Leaders need to ensure that appropriate resources are made available for a credible evaluation of the Always Events initiative. During the evaluation phase, it is important for leaders to reinforce a culture of continuous improvement and organizational learning. To sustain the momentum and spread of Always Events, leaders should communicate the impact of the initiative and describe it in the context of achieving the broader goals of improving the experience of care for patients, care partners, and service users.

Throughout the Always Events initiative, it is crucial to have stable leadership. Handoffs between day-to-day leaders as a result of leadership transitions are disruptive to all improvement initiatives

and can make the implementation of an Always Event nearly impossible. Thus, orientation and ongoing support for staff assuming new leadership roles for the Always Events work is essential.

Establish an Oversight Team

If an executive leadership committee for improving patient experience does not exist, convene a multi-stakeholder team with representatives in various roles within the organization, including patients and their care partners, to provide leadership and oversight for improving the experience of care for patients and family members (see Table 2). This oversight team should represent a broad group of stakeholders and be large enough to ensure that the work is not dependent on one individual. Teams can experience turnover or transfers in staff members, so the team should be large enough (and engaged) that the work can move forward even with staff changes.

The oversight team oversees all aspects of the Always Events initiative, including organization-wide spread of Always Events, and helps coordinate and integrate all initiatives aimed at improving the patient care experience. Communications and messaging about the Always Events is also a key priority for the oversight team.

Table 2. Oversight Team Roles and Responsibilities

Role	Responsibilities	Team Member Name(s)
Executive leader	The role of the executive leader is to link the goals of the Always Events initiative to organizational strategic priorities, and to provide oversight and guidance to their teams' work. What resources and expertise in quality improvement and data analysis will support improvement efforts? Depending on the size and organizational structures, executive leaders may include Chief Nursing Officers (CNOs), Directors of Nursing, Medical Directors, Quality Improvement or Program Leaders.	
Day-to-day leader	The day-to-day leader is responsible for coordinating the initiative activities and providing guidance, coaching, and support to the team in the pilot site. The day-to-day leader has dedicated time to support the Always Events initiative.	
Oversight team members	The oversight team includes organizational leaders, clinicians from a variety of professional disciplines, and staff that represent a cross-section of key representatives and stakeholders committed to ensuring the success of efforts to improve the experience of care for patients, their family members, and service users.	
Patients, family members or other care partners, and service users	Use existing groups to the extent possible. Recruiting members of an existing Patient Advisory Committee is one possible approach. Patients, their care partners, and service users should represent the age, race and ethnicity, or socioeconomic status in your organization. For resources on how to recruit patients and family members see IPFCC.org .	

Identify Opportunities for Improvement and Align with Strategic Goals

Efforts to create Always Events should address opportunities for improving the care experience for patients, their care partners, and service users that are aligned with organizational strategic goals. To better understand improvement opportunities, the organization’s oversight team should collect and review quantitative and qualitative data. Use Table 3 below for data collection and summary.

Table 3. Opportunities for Improving the Experience of Care

Source	Description	Your Synthesis
Review strategic plan	Why is improving patient experience a strategic priority? What initiatives or other projects are already underway or planned? How will Always Events help achieve your organization’s priorities and goals for improving the experience of care for patients, family members, and service users?	Key strategic priorities: 1. 2. 3. How do Always Events link to priorities?
Review patient experience data	Patient experience data might include data from surveys (e.g., Friends and Family Test survey data), written comments, feedback from Patient Advisory Committee meetings, and complaints. What do your sources of patient experience data tell you about the greatest opportunities to improve the experience of care? Note any particular clinical sites, groups of patients or individuals, or areas where there is significant opportunity for improvement.	Opportunities for improvement: 1. 2. 3. Specific programs, units, or patient populations where significant opportunities for improvement exist: 1. 2. 3.
Talk to patients, family members, and service users	Conduct Patient Advisory Committee meetings, interviews, or focus groups with patients, family members, and/or service users. From their perspectives, what are the major opportunities to improve the care experience?	Major opportunities for improvement: 1. 2. 3.
Talk to clinicians and staff	Conduct interviews or focus groups with clinicians and staff. What do they see as the major opportunities to improve the care experience for patients, family members, and service users?	Major opportunities for improvement: 1. 2. 3.
Other methods	Select other methods to identify key opportunities for improving the care experience.	
Area of focus for the Always Event	Given the data and information collected (above), the general focus for the Always Event will be: (List here)	

Select a Pilot Unit, Clinical Program, or Population to Co-design Always Events

Select one pilot unit, clinical program, or population to co-design Always Events. This pilot unit should address the area of focus for the Always Event noted above (see Table 3). For example, if a main theme is “information during discharge,” the pilot unit should have enough discharges to do rapid-cycle testing of changes the team hopes will lead to improvement. It is vitally important to start small with this work and not try to take on more than one unit to begin. This pilot site will co-design and test an Always Event, learning from iterative cycles of testing and redesign in order to successfully implement the Always Event. Success in this initial site will help build motivation and organizational momentum for spread. Some organizations will want to select a pilot site or area based on the data review and others may select a pilot area with a leader that is particularly interested in or excited about the Always Events work.

The pilot site should have the following characteristics:

- **Capability to manage a quality improvement (QI) initiative:** In order to pilot test the Always Events, the unit or program leader and staff need a minimal level of improvement capability knowledge and experience. The pilot site should have some history of successful improvement efforts.
- **Ability to take on the improvement initiative:** Most health care providers have a large workload, and organizations should avoid selecting clinical areas that are already undergoing major change or large change initiatives.
- **Desire to partner with patients, their family members or other care partners, and service users:** The pilot site should have a leader that is interested in providing leadership and coaching for building effective partnerships between clinicians and staff, as well as patients, their care partners, and service users.
- **Champion staff member:** The pilot site should have at least one well-respected staff member that is interested in partnering with patients, care partners, and service users to create and implement an Always Event.

Recruit a Point-of-Care Improvement Team for the Pilot Work

Once the pilot unit or program has been identified, the day-to-day leader identifies a core point-of-care improvement team that will be dedicated to creating and implementing an Always Event (see Table 4). Convene patients, family members, clinicians, and staff to form a point-of-care improvement team for the pilot work in a specific unit or clinical program.

Table 4. Point-of-Care Improvement Team Role and Responsibilities

Role	Responsibilities	Team Member Name(s)
Day-to-day leader	The day-to-day leader is responsible for coordinating the Always Events initiative activities and providing guidance, coaching, and support to the point-of-care team in the pilot site. The day-to-day leader has dedicated time to support the Always Events initiative.	

Point-of-care team members	The day-to-day leader identifies an interdisciplinary team to co-design and implement the Always Event. This point-of-care improvement team includes clinicians and staff in different roles with a variety of perspectives and skills. The day-to-day leader develops a process and structure for the initiative, such as a meeting schedule and division of responsibilities at various stages of the initiative. The acquisition of new skills (such as testing new change ideas on a small scale) and behaviors (such as co-designing Always Events in partnership with patients/individuals and family members) is a critically important component for the successful implementation of an Always Event.	
Patients, their family members or other care partners, and service users	Clinicians and the day-to-day leader collaborate on approaches to engage patients, care partners, and service users in the point-of-care improvement team to create the Always Event. Without such participation, improvement efforts — no matter how successfully implemented — may not accurately reflect what matters to patients and their family members when it comes to their desired care experience. In addition, patient and family member input and suggested ideas for change are invaluable and critical to the ultimate success of the Always Events initiative.	

Co-design and Test an Always Event

Understand “What Matters to Patients?” in the Pilot Unit or Program

After the point-of-care improvement team has been recruited, the first step in co-designing an Always Event is to deeply understand what matters to patients, family members, and service users in the pilot unit or program. There are numerous options for learning about important issues and opportunities to improve care experiences, including the following:

- See the care experience with “new eyes.” Bring staff and patients together to hear each other’s perspectives, making sure patients and family members feel comfortable with being honest and open about their experiences. Prepare patients, family members, service users, and staff to make sure the time together is productive.
- Conduct observations of the processes to be improved (e.g., discharge preparations, care coordination in home health care, etc.) and/or use interviews, shadowing, focus groups and/or storytelling to gain a deeper understanding of actual care experiences.
- Conduct interviews or focus groups to discuss patient and service user experience. Ask people to share their stories of things that have gone well or that could be improved in your organization. Interviews can be conducted informally. For example, one organization conducted one-on-one interviews with people in a waiting room. Another organization hosted informal sessions for service users to stop by and discuss experiences.
- [Observe patient experiences](#) firsthand by putting yourself “in the shoes” of patients and/or family members, and note your observations and ideas for improvement.
- [Use shadowing](#) to conduct an in-depth observation.

- Use technology to gather and share information. [Ashford and St. Peters NHS Trust in England produced a video](#) as part of the process of developing an Always Event for people with Alzheimer’s and dementia and their caregivers.
- Conduct observations and interview clinicians and staff. When conducting interviews, ask what staff think is going well regarding the processes to be improved and what are the challenges to creating a better experience for patients and their family members.

Use this information to hold a meeting at which staff, patients, family members, and service users are all present. Identify specific themes and opportunities for improvement. Do not begin to summarize too quickly. Allow as many staff as possible to be in the room and hear directly from patients, family members, and service users. Ensure that the problem statement for the Always Events initiative represents the voices of patients and family members. Listen carefully and actively; be careful to listen for new information, not just to confirm pre-existing beliefs.

Create a Vision Statement and Develop an Aim Statement

The information gathering described above helps the point-of-care improvement team identify the greatest opportunities for improving care experiences in the pilot unit or program. To focus the work, the team needs to articulate a vision for the Always Event, developed in partnership with clinical team members, patients, family members, and service users.

Once the vision statement is created, the next step is to develop an aim statement to guide improvement efforts. The aim statement for the Always Event: 1) specifies how much improvement is expected; 2) identifies a time frame and end date for the improvement initiative; and 3) defines the specific population of patients or service users that will be affected.

1. Start with the end in mind

- What care experience or process do you hope to “transform” with the Always Event? If successful, what improvements will have a big impact on care experiences for patients/individuals?

2. Articulate the vision for the Always Event in the voice of the patient or service user

Example: “I always receive the support I need in moving on.” (which refers to supporting people during transitions in care) — Lancashire Care (UK)

Example: “My care team always understands what matters to me.” — [Sutter Care at Home \(US\)](#)

Example: “I always know what to do when I get home or, if not, I know who to contact.” — Blackpool Teaching Hospital (UK)

Example: “I have a better understanding of how to take my medications and how to care for myself after discharge from the hospital.” [Always Use Teach Back — UnityPoint Health \(US\)](#)

3. Create an aim statement (how good, by when?)

- Where (specific unit, program, or population)

- What will improve
- Measurable goals (numerical targets)
- By when (specific date)
- Do patients/individuals and family members view this aim for an Always Event as a relevant priority?

Example: By March 1, 2016, the nursing staff asks every patient, “What matters to you?” during the infusion appointment, documents the issues that are important to each patient, and ensures that there is a plan in place to meet the patient’s needs, values, and preferences 90% of the time.

Example: By March 1, 2016, 95% of patients on the cardiovascular unit demonstrate an understanding of the signs and symptoms that may occur related to their specific clinical condition, and specific actions to take if they occur; and 95% of patients on the cardiovascular unit are given a contact person to call, if they have any worries or concerns after they are discharged to home.

Co-design an Always Event

Once the Always Event aim statement is developed, the team needs to identify ideas for making that statement a reality through new approaches or practices. Ideas are generated through co-design and collaboration among the clinical team, patients, and family members, and such discussions require strong facilitation.

A variety of methods can be used to generate new approaches or changes to contribute to the Always Event.

- Adapt and adopt evidence-based practices and competencies (e.g., use Teach Back to assess what patients understand after discharge teaching).
- [Brainstorm new ideas](#) and select favorite ideas to [test](#).
- Use [Experienced-Based Co-Design](#) (EBCD) to co-design services. EBCD is defined by The King’s Fund as “an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership.” There is a free toolkit available for download from [The King’s Fund website](#).

Test Specific Change Ideas for the Always Event

In some cases, the Always Event will be one actionable behavior or change such as asking patients “What matters to you?” at every visit or during hospitalizations.

In other situations, Always Events may consist of multiple changes or process improvements. For example, an Always Event to ensure that patients (and their care partners) always understand how to care for themselves after discharge might include three distinct components or process improvements, such as:

- Develop patient-friendly discharge instructions;
- Include a Teach Back session to ensure patients and their care partners understand the discharge instructions; and

- Provide a contact person to call if the patient has worries or concerns.

After the clinical team and patients/individuals and family members have generated new change ideas to co-design an Always Event, the point-of-care improvement team will need to test new actionable ideas and process changes for improving the “care experiences that matter.” Testing individual changes helps the point-of-care improvement team quickly learn about which new ideas should be adopted, adapted, or abandoned.

Patients and family members can increase the effectiveness and learning from the testing of new ideas. For example, patients and family members may have ideas about when during the hospital stay Teach Back may be most useful.

[Plan-Do-Study-Act \(PDSA\)](#) is a method for action-oriented process improvement using rapid-cycle tests of changes. The point-of-care improvement team conducts small-scale tests of change in real work settings — by planning a test (Plan), trying it (Do), observing the results (Study), and then making adjustments to the test (Act). Observation yields significant learning as a team tests and then implements changes.

Why Test New Change Ideas?

- To increase your belief that the change will result in improvement;
- To decide which of several proposed changes will lead to the desired improvement;
- To evaluate how much improvement can be expected from the change;
- To decide whether the proposed change will work in the actual work environment in the pilot unit or program;
- To decide which combinations of changes will have the desired effects on the important measures of quality;
- To evaluate costs, impact, and possible unintended consequences from a proposed change; and
- To minimize resistance to implementing the successful changes.

How to Test a Change

A first test of change usually happens on a small scale (e.g., using Teach Back with one nurse or one patient or for one day). Use a [Plan-Do Study-Act \(PDSA\) Worksheet](#) and predict what will happen as a result of trying something different. Observe the results, learn from them, and continue to the next test. Most changes require a series of successive tests before implementation. Often a test is expanded or adapted to be more useful, or sometimes it’s abandoned altogether if the change does not yield positive attributes. Use iterative PDSA cycles to test under a variety of conditions ([see Appendix B](#) for an example of iterative PDSA cycles). This improves the team’s belief that the change will result in improvement reliably when implemented.

Suggestions for Conducting PDSA Cycles

- Keep tests small; be specific. Note: Running multiple small tests of change simultaneously will accelerate learning and improvement.
- Make a prediction about what will happen if the tests succeed.

- Each test informs the next. Expand test conditions to determine whether a change will work in a variety of conditions or in different situations:
 - Times, such as day and night shifts, weekends, holidays
 - Staffing, such as when the unit is adequately staffed and when there are staffing challenges
 - Types of patients, such as those with lower health literacy, non-English speaking patients, short stay or long stay patients
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment. Compare data to findings to learn more and design future tests.
- Continue PDSA cycles of learning and testing to improve process reliability.

Specify Details of Successful Changes for the Always Event

After the point-of-care improvement team has tested the ideas and feels confident that the identified behaviors and/or improved processes results in improvement, the Always Event should be translated into standard work. Don't aim for perfection in this first iteration of standard work because the team may learn adaptations that work better after it is tested.

The organization should specify the details for implementing each of the successful change ideas that were tested (specific process improvements or behavior changes) for the Always Event:

- Who will do it?
- What will they do?
- When will they do it?
- Where will they do it?
- How do they do it (include tools that are used)?
- How often will they do it?
- Why should they do it?

Reliably Implement an Always Event

Reliably implementing an Always Event means delivering on the “always” for all patients — in other words, the care experience we promise for all patients and their family members, every time. The process of making an Always Event reliable consists of a series of PDSA cycles.

Before conducting PDSA cycles to learn how to reliably implement an Always Event, design the Always Event with two principles in mind: simplification and standardization. Whenever possible, make it easy to do the right thing. A reliable system makes use of human factors principles (e.g., build on existing habits, use checklists to avoid relying on memory, foolproof the process so that it is impossible to do the wrong thing, use standard protocols and training).

For example, your Always Event might entail integrating new questions or processes into a checklist or into the electronic medical record workflow. As you start to implement the Always Event, there will be a tendency to make the process more complex. The introduction of complexity

is natural, but the goal of the team is to ensure simplicity and standardization through the various iterations of testing.

PLAN: Communicate New Standard Work Processes to Clinicians and Staff

Identify all individuals that will be involved in the new processes. Once identified, all unit or program staff need to understand the new standard work. Make sure that everyone is trained in new skills or competencies and in new process improvements. Use various communication mechanisms for this training (e.g., presentations, electronic information, check lists, and support tools). Consider using peers and champions to help communicate the purpose and details regarding the new work processes.

DO: Teach, Coach, and Support Implementation

Tips for Training for Skill from *Getting to Standard Work in Health Care*:

- Learn what clinicians and staff already know (“know what,” “know how,” “know why”).
- Coach or mentor one-on-one or one-on-two, as needed.
- Perform actual demonstrations using job aids (Teach Back example included in [Appendix C](#)), followed by repeat demonstrations; repeat until skills are acquired.
- Follow-up within one or two days after training to ensure skills have been sustained.
- Observe when the process doesn’t work, or when explanations are not clear or not appropriate.

STUDY: Observe and Reflect

Use quantitative data and qualitative observations to understand progress:

- Build in time for the improvement team to reflect on the progress of reliably implementing the Always Event. Review the quantitative and qualitative data, and identify opportunities and challenges.
- Use [process measures](#) to assess progress regarding reliable implementation. When data suggest a lack of process reliability, ask clinicians, staff, and patients and family members about barriers and challenges. Identify opportunities to execute the new processes more reliably. Assume the source of the problem is inadequate process design, not people. Work with the improvement team to continue to co-design process improvements to reliably implement the Always Event.
- Observe the process. Observations can tell you fairly quickly what the barriers to implementation might be. As you start to reliably implement the changes to achieve the Always Event, be sure to create a learning system that helps you increase reliability. Use observation and feedback from clinicians, staff, and patients and family members regarding how to improve processes or training. Understanding common failures in critical steps (i.e., situations when a process is not executed as expected) helps the team redesign processes to eliminate those failures.
- Examples of defects include a busy clinician forgetting the Always Event, individuals unwilling to participate in the Always Events work, forgetting to document the result of

conversation, or each clinician thinking the other is executing the new process. Early defect identification will help the team anticipate barriers and consider a reliable design.

ACT: Redesign Standard Work as Needed to Increase Reliability

Based on your “Study,” identify a series of changes to revise standard work for the Always Event. If a critical step was missed, consider ways to reduce the reliance on memory for that step. For example, if you relied on a discharge nurse to remember to use Teach Back, consider including a prompt for clinicians in the existing process, whether that’s a checklist, note sheet, or electronic medical record alert. Remember to go back to the “Plan” phase as you update the design of standard work.

Sustain and Spread Always Events

Sustaining Always Events

The work does not end once the process has been reliably implemented in the unit. The change needs to be transferred from an improvement project to “the way we do things.” Sustaining Always Events requires thoughtful planning in three key areas:

1. **Ownership:** During implementation, the work should be transferred from an ad hoc improvement team to a permanent process owner. The process should be written into job descriptions and formalized as a role. Consider what would happen if the improvement team leader left tomorrow. Would the process continue to be sustained? If not, what would make the work more permanent?
2. **Data and measurement:** Outcome measures need to be reported and tracked at the hospital or system level as well as at the unit level in order to provide leaders, unit managers, and frontline staff with regular feedback on their progress. Thinking through the data you want to collect and how you will monitor this data is an important piece of sustainability. Identify when and how you will intervene if process reliability begins to slip.
3. **Develop structures to “hardwire” the change:** What infrastructure is needed to make the change permanent? Once you have high confidence in the change, you will need different infrastructure and support. This usually requires revisions to written policies, hiring, training, compensation, electronic work aids in the electronic medical record, equipment, and other aspects of the organization’s infrastructure that were not engaged in the testing phase.

Spreading Always Events

The oversight team should be thinking about spread at the start of the Always Events initiative, designing a plan that answers the following questions:

1. What is full scale? If successful, what’s the total population or total number of units that the Always Event will be spread to?

Example: All patients discharged from the hospital, which is an average total of 45 patients per day.

2. Where will you start? This is outlined in the initial steps in much more detail, but it is important to know where you plan to start the Always Event and how quickly it will take to move from testing to implementation.

Example: Unit 5B (the pilot unit) will take six months to co-design, test, and implement the Always Event.

3. What is the pathway for change? What unit(s) or population(s) will implement the Always Event after the pilot unit? How long will it take to go to full scale?

Example: Units 5A and 5C will adopt the Always Event next. Based on pilot testing in Unit 5B, this should only take three months in 5A and four months in 5C. We will then spread to all of Units 1 through 4 (where relevant).

When considering spreading an Always Event, it is important to be thoughtful about the process of spread and gaining buy-in from other units, including considering how to customize the changes to the unique needs of different units and how to use pilot sites as messengers and champions for change across the organization. IHI's "[Seven Spreadly Sins](#)" provides tips for avoiding some common pitfalls during spread (also included in [Appendix D](#)).

Appendix A: NHS England Trust Pilot Sites Engaged in Testing Always Events

Trust Name	Area of Focus	Brief Description of Always Event
Lancashire Care	Learning Disabilities Service	We will always support you in moving on in care
Aintree University Hospital	Medicine Ward and Major Trauma Ward	Open visitation for family members
Ashford and St. Peters	Dementia-Friendly Medical Ward	What matters to you and your care partner?
The Royal Marsden	Haematology Day Care Unit	Patients get the right information at the right time Simple question during each consultation re: information you need
Blackpool Teaching Hospitals	Stroke Ward	Patients always know what to do when they get home or, if not, they know who to contact
Southampton	G9-Transitional Ward	Involvement of patients and family members in planning for discharge
University Hospitals Morecambe Bay	Post-partum Ward	Everyone is offered the opportunity of a birth partner remaining with them for the first 24hours after birth.
Calderdale and Huddersfield	Outpatient Vascular Clinic or Orthopaedic Clinic (physician-led clinic)	Patients understand their clinical conditions and treatment plans; clinical team understands “what matters to patients”
Kent Community Health NHS Foundation Trust	Neurology Rehabilitation Unit in a Community Hospital	Co-design of personalized care plans
Taunton and Somerset	Antenatal Patient Information	Focus on giving people the right (evidence-based) information, at the right time, at their fingertips (booking appointment pack and birth pack)

Appendix B: Example Iterative PDSA Cycles for Testing an Always Event

These example PDSA cycles focus on testing an Always Event to assess and address what matters to each patient.

Cycle 1: One nurse, on one day, tests asking one patient during the hospital admission assessment about what is important to them and what needs to be addressed during the hospital stay.

- Learning – Patient seemed overwhelmed and did not respond to the questions, so the nurse conveyed this information to the nurse on the next shift.

Cycle 2: One nurse, on one day, tests asking one patient about what is important to them on that day.

- Learning – Patient did not immediately respond to the question, so the nurse asked if the patient had any worries or concerns. The patient immediately responded by describing her worries. The nurse documented what was learned in the progress notes.

Cycle 3: One nurse, on one day, tests asking one patient, “Do you have any worries or concerns about going home?”

- Learning – Patient was concerned about the cost of his medications, so the nurse conveyed this information to the multidisciplinary team and the social worker discussed options for getting the needed medications.
- Huddle with nursing staff to discuss what was learned during the first three tests:
 - Explorations of asking patients, “What matters to you?” will at times require rephrasing of questions. “What matters to you?” should not be a script, but rather a concept to guide the dialogue with patients.
 - Important touch points during the hospitalization — admission, daily assessments, and discharge preparations — are likely to be times when nurses can ascertain what is important to patients. That said, the patient’s clinical condition or ability to engage in a meaningful conversation during each of these touch points may not be possible. Thus, asking patients and their family members, “What matters to you?” or “What is important for us to address today?” as a consistent nursing practice is the first step in understanding how to customize care for that patient.
 - Understanding and communicating to the entire care team what is important to each patient is the first step — putting a plan in place to address the issues that have been raised by the patient is the second step. Oftentimes, this will require involvement of various members of the multidisciplinary care team.

Cycle 4: All nurses, on one day shift, test asking each patient they admit about what is important to them to address during the hospital stay.

- Learning – Most patients were able to describe their worries and concerns about being hospitalized or their inability to manage their care at home, and nurses shared this information at the change of shift reports.

Cycle 5: All nurses, on one day shift, test asking each of their patients about what is important to them on that day.

- Learning – Nurses tried a variety of approaches to learn about what was important to patients and their family members. The nurses documented what was learned in the progress notes, and some used the whiteboards in patient rooms to convey issues to be addressed to the entire care team.

Cycle 6: All nurses, on one day shift, test asking each patient being discharged about any worries or concerns they had about going home.

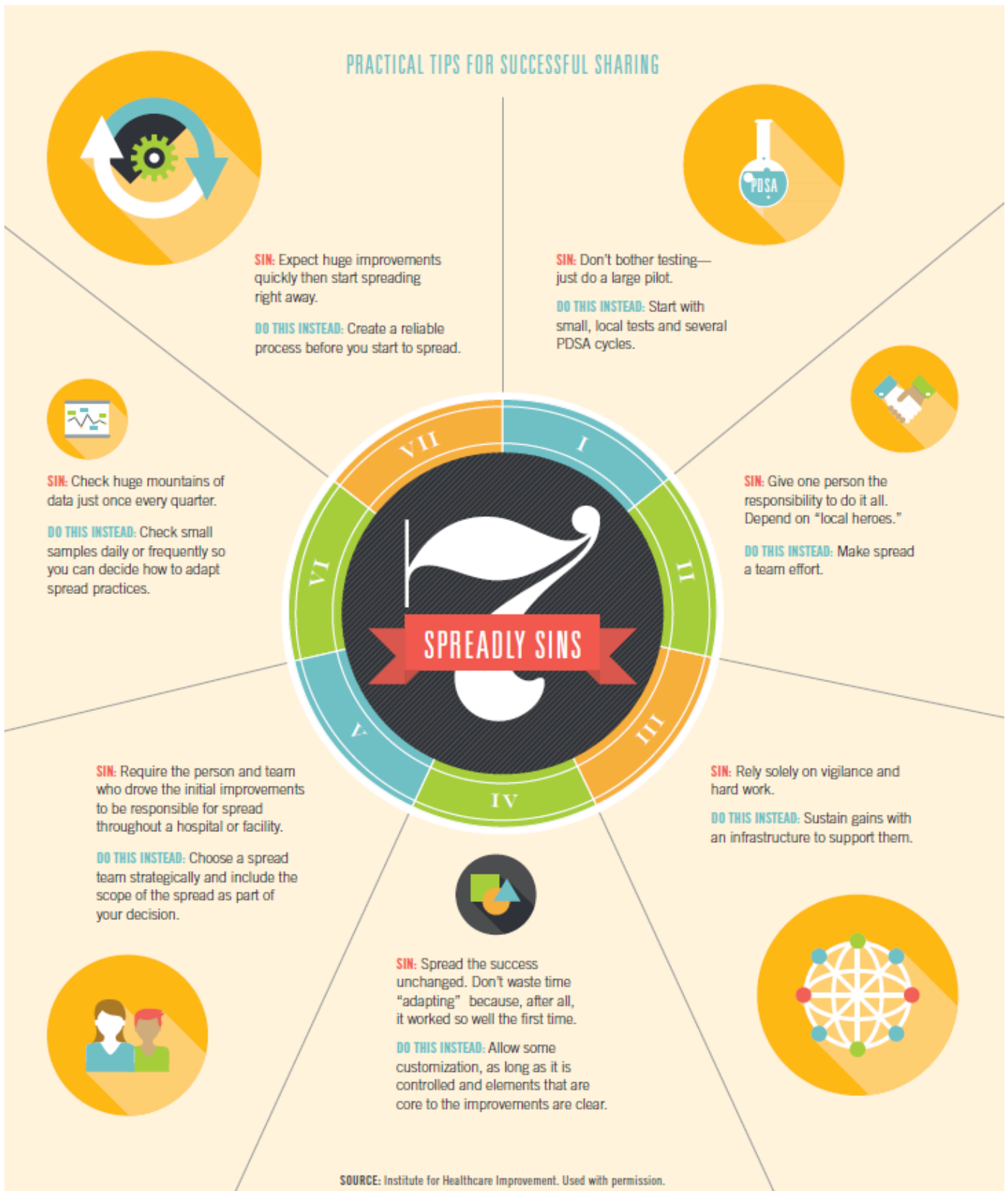
- Learning – Many patients verbalized worries and concerns about being discharged, and the multidisciplinary care team discussed ways to learn about these concerns earlier in the hospital stay.

Additional cycles of testing and learning are usually required to reliably understand and address the comprehensive needs and goals of the patients and family members.

Appendix C: Example of Always Event Standard Work

What is the focus of the Always Event?	Assess and address what matters to each patient.
Who will do it?	RNs assigned to the patient during the hospitalization.
What will they do?	RN asks every patient “What matters to you?”, documents the issues that are important to each patient, and ensures that there is plan in place to meet the patient’s needs, values, and preferences.
When will they do it?	At key touch points during a hospital admission: 1) on admission, 2) during daily nursing assessments, and 3) during preparations for discharge to home or to the next community care setting.
Where will they do it?	In all inpatient units, at the patient’s bedside.
How do they do it (include tools that are used)?	RNs customize questions and approaches to understand “What matters?” to individual patients at each touch point. Tools include daily assessments in the progress notes, discharge plan, and whiteboard at the bedside.
How often will they do it?	On admission, daily during nursing assessments, and during discharge preparations.
Why should they do it?	Nurses seek to understand the comprehensive needs and goals of the patients and family members they serve. Yet, in the busy world of clinical care, there are innumerable situations in which what really matters to individual patients is not understood and addressed. The standard work supports nurses in reliably assessing and addressing the issues that are most important to each patient. What would we discover by making this as important and as consistent a practice as the safety steps in medication administration?

Appendix D: IHI Seven Spreadly Sins



Appendix E: References and Resources

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