Institute for Healthcare Improvement

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Doha, Qatar

Leadership for Safety

Middle East Forum on Quality and Safety in Healthcare

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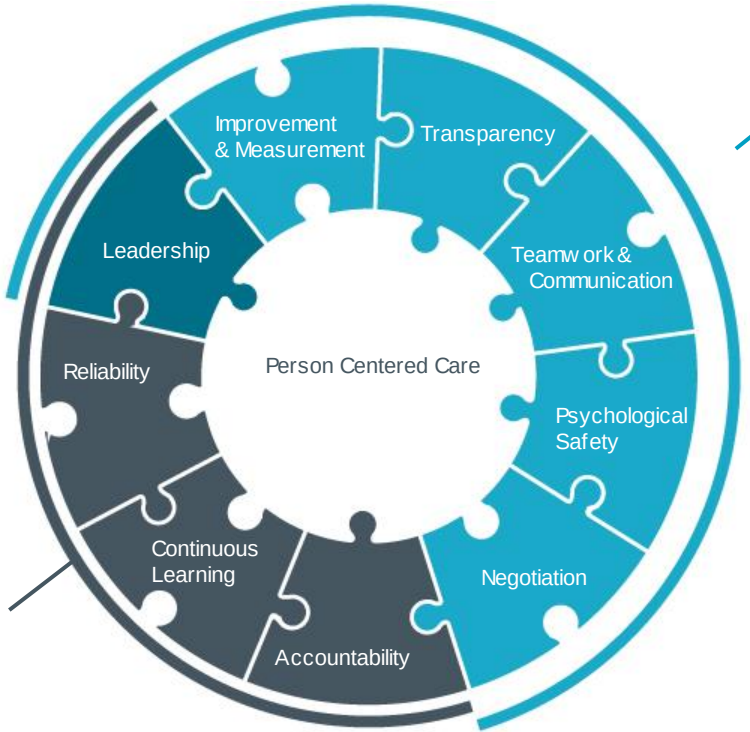
“People who say it cannot be done should not interrupt those who are doing it.”

- George Bernard Shaw

Patient Safety Framework



Culture

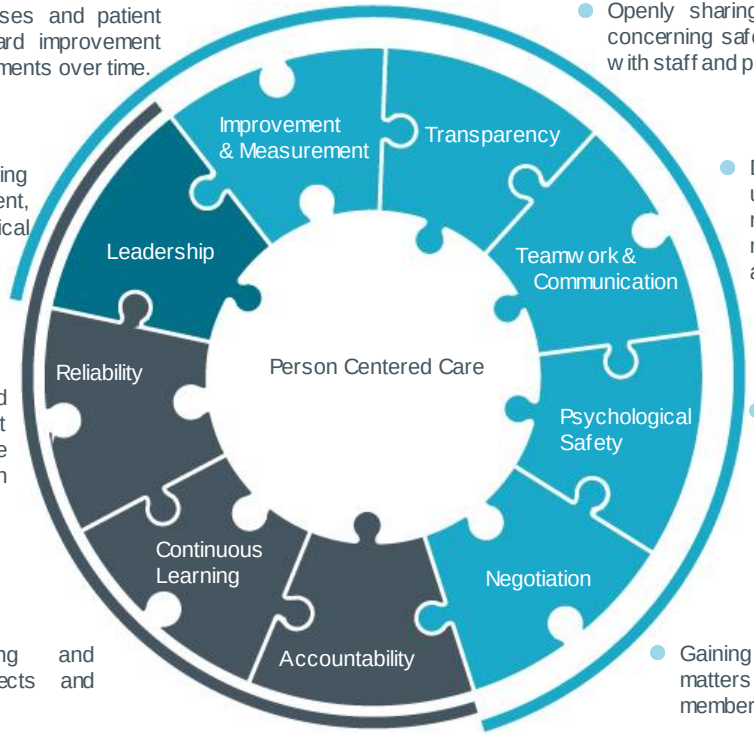
"…the product of the individual and group values, attitudes, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety programs."

Learning System

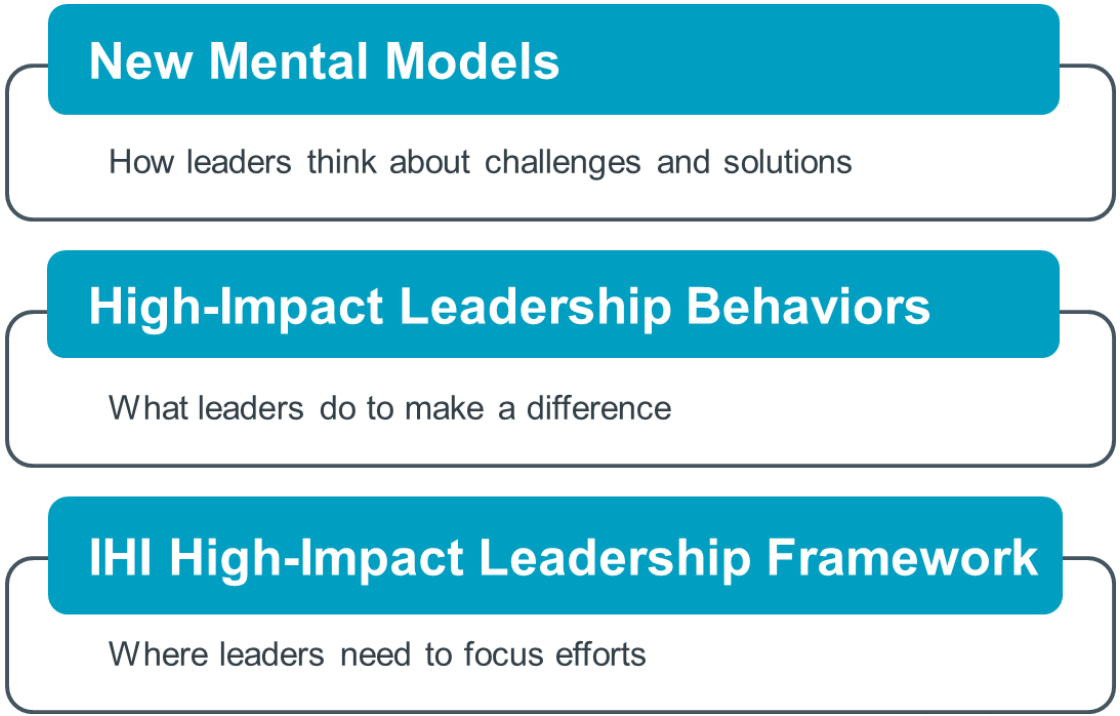
A learning system collects and analyzes social, clinical and operation metrics based on a strategic plan; engages multidisciplinary teams to debrief and put into action processes (PDSA) to improve the outcomes and incorporate a continuous feedback loop to reassess if the new processes has generated better social, clinical and operational outcomes.

Patient Safety Framework

- Improving work processes and patient outcomes using standard improvement tools including measurements over time.
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.
- Facilitating and mentoring teamwork, improvement, respect and psychological safety.
- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations
- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.
- Regularly collecting and learning from defects and successes.
- Gaining genuine agreement on matters of importance to team members, patients and families.
- Being held to act in a safe and respectful manner given the training and support to do so.



Interdependent Dimensions of High-Impact Leadership



Swensen S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. Cambridge, MA: Institute for Healthcare Improvement; 2013. Available on www.ihi.org.

High-Impact Leadership Behaviors: What leaders *do* to make a difference

1. Person-centeredness	Be consistently person-centered in word and deed
2. Front Line Engagement	Be a regular authentic presence at the front line and a visible champion of improvement
3. Relentless Focus	Remain focused on the vision and strategy
4. Transparency	Require transparency about results, progress, aims, and defects
5. Boundarilessness	Encourage and practice systems thinking and collaboration across boundaries

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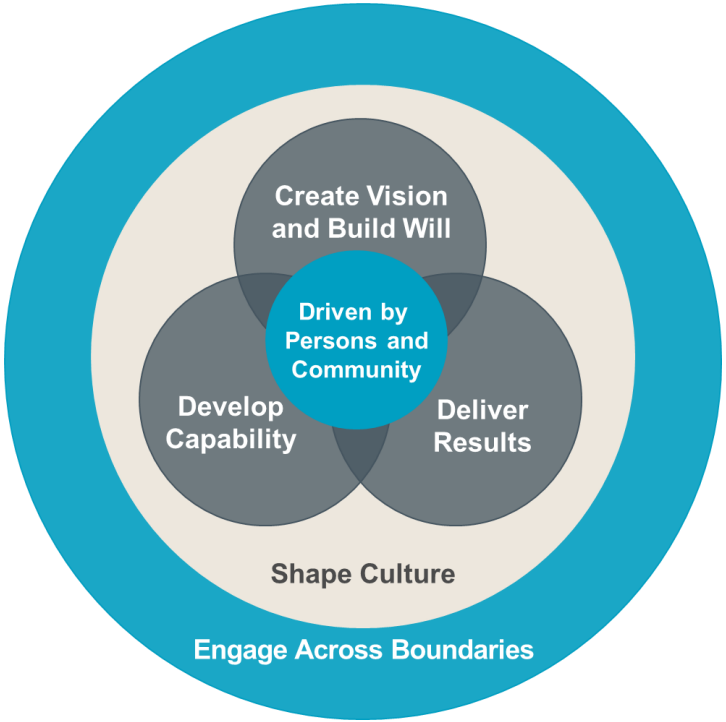
IHI High Impact Leadership Framework



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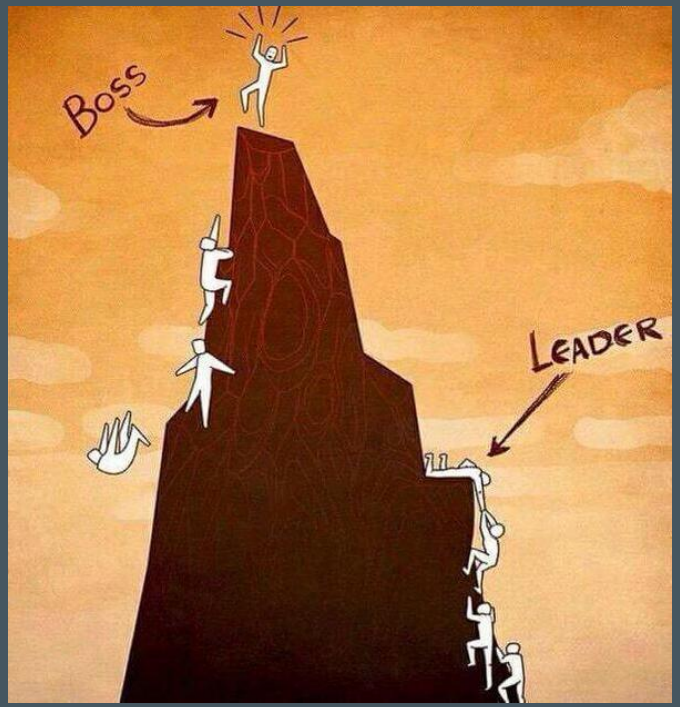
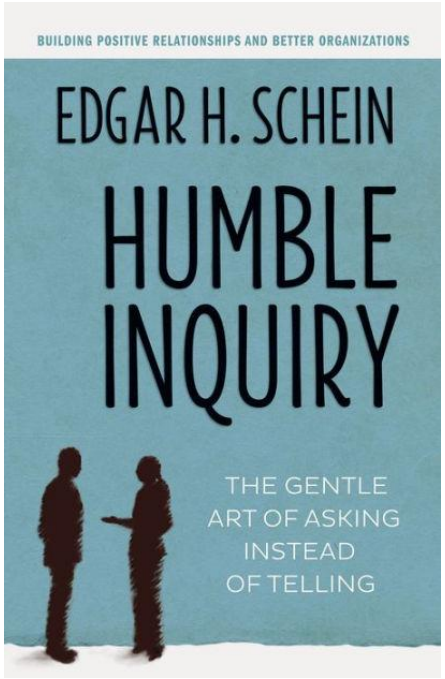
Patient safety creates new demands on leaders



Some keys for the new mental models

- Asking, not telling
- Partnerships (staff, patients, communities)
- Shaping culture

Humble Inquiry



"If a goal of conversation is to *improve* communication and build a relationship, then telling is more risky than asking.

Asking temporarily empowers the other person and temporarily makes me vulnerable."

High-Impact Leadership Behaviors: What leaders *do* to make a difference

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Person Centeredness: Be consistently person centered in word and deed

Choosing Wisely Canada
In partnership with the Canadian Medical Association

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ACADEMY OF MEDICAL ROYAL COLLEGES WALES
ACADEMI COLEGAU MEDDYGOL BRENHINOL CYMRU

PATIENTFIRST
PREVENTING HARM IMPROVING CARE
22-23 NOVEMBER 2016 EXCEL LONDON

Choosing Wisely®
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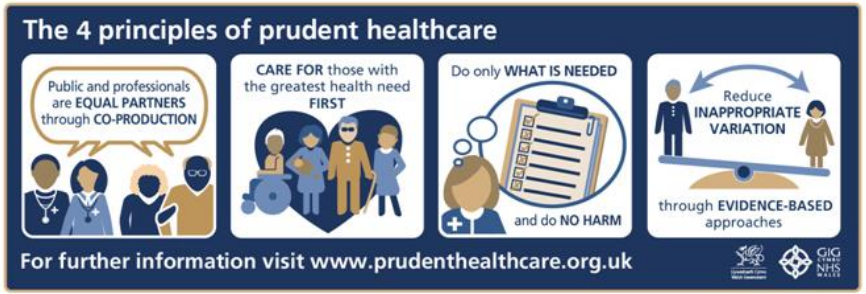


Crossing the Quality Chasm – Institute of Medicine, 2001

- Ten rules for the redesign of healthcare
- 1. Care is based on continuous healing relationships – when and where needed
- 2. Care is customized according to patient's needs and values
- 3. The patient is the source of control – information given, shared decisions

NHS
Improving Quality

What people tell us

"We are sick of falling through gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care. We do not accept being discharged from a service into a void. We want services to be seamless and care to be continuous."

National Voices

The four principles of person-centred care

What are the advantages?

- Increased patient satisfaction/patient experience
- Increased staff performance and morale
- Fewer complaints
- More coordinated care
- More likely to stick to treatment plans/comply with medications
- Better health outcomes and healthier behaviors
- Patient activation
- Decreased use of emergency services, notably in chronic conditions

Some examples of person-centeredness:

- Person and family centered care
- Personal health budgets
- Schwartz rounds
- Self-management support
- Shared decision making/Choosing Wisely
- “What matters to me” boards
- Hello, my name is . . . . .

Front Line Engagement

Be a regular authentic presence at the front line of care and a visible champion of improvement

Walkrounds – Safety Climate

- Executive Walkrounds Study:
  - Randomized 24 clinical units to receive EWRs or usual patient safety activities and measured safety climate of nurses before and after walkrounds
  - At baseline the experimental and control groups had similar safety climate scores
  - After the intervention, 72.9% of nurses in the walkrounds group reported a positive safety climate versus only 52.5% in the control group

Thomas et al. BMC Health Services Research 2005;5:28 For other data on walkrounds also see Frankel et al. Health Serv Res 2008:Jul 20:2.

Don’t walk past

Stay true to your values:

The values that are shared across Scotland's Health Service are:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

Relentless Focus:

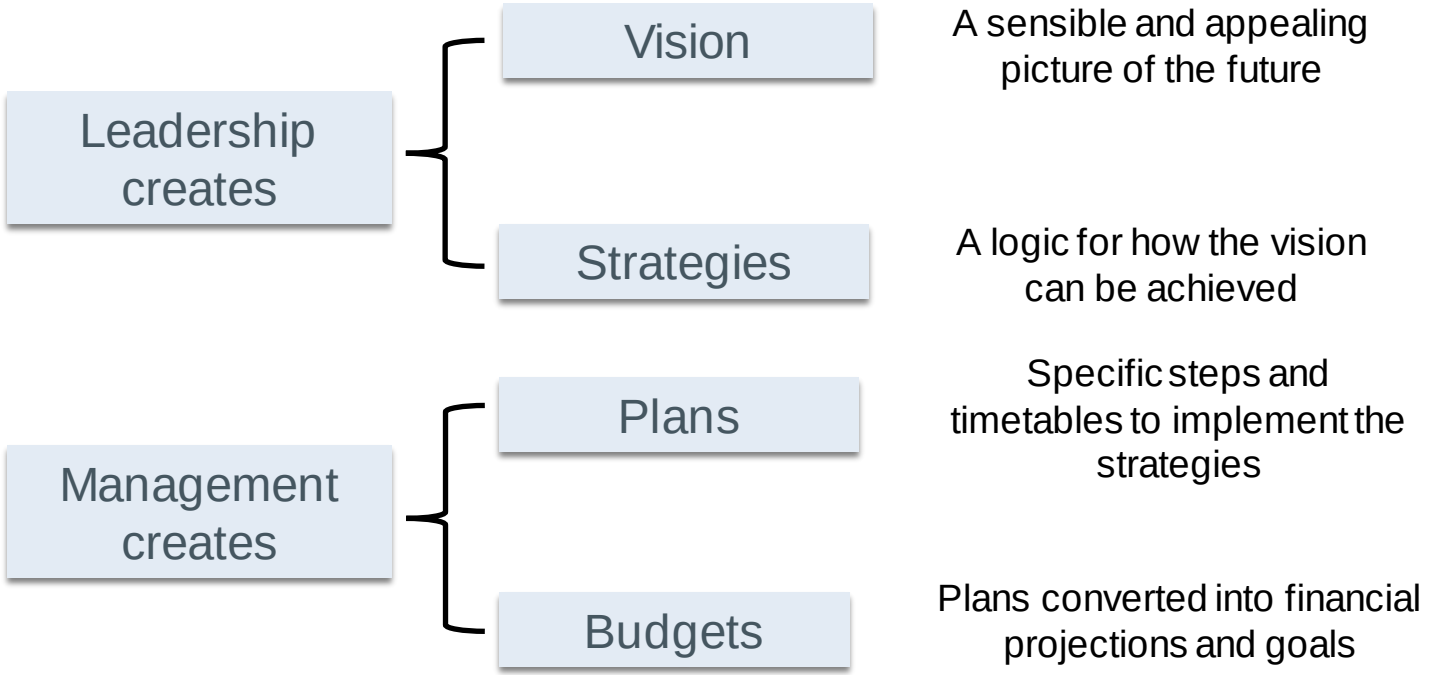
Remain focused on the vision and the strategy

- Develop a clear vision
- Create a sense of urgency
- Appoint the most effective leaders to the highest priority projects

Urgency vs. Complacency

- The absence of a major visible crisis
- Too many visible resources
- Low overall performance standards
- Organization focus on narrow goals
- Focus internally on wrong KPIs
- A lack of external performance feedback
- Culture of kill the messenger, low candor, low confrontation
- Human nature – denial
- Too much happy talk from senior management

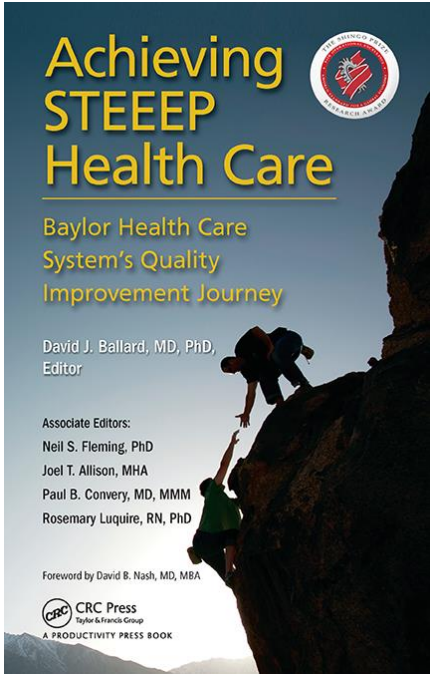
Vision, strategies, plans, and budgets



Characteristics of an effective vision

- Imaginable
- Desirable
- Feasible
- Focused
- Flexible
- Communicable


Salford
Royal
© Alamy


Achieving
STEEEP
Health Care
Baylor Health Care
System's Quality
Improvement Journey
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CRC Press
Taylor & Francis Group
A PRODUCTIVITY PRESS BOOK


2008 > 2009 > 2010 > 2011 > 2012 > 2013 > 2014 >
Over 7 years we have achieved:
in the best 10% nationally we have continued to maintain our position for risk adjusted mortality
100% reduction in MRSA blood stream infections
90% reduction in Clostridium difficile infections
51% reduction in cardiac arrests
70% reduction in pressure ulcers
8.7% reduction in risk adjusted weekend mortality
over 420 days without a MRSA blood stream infection
96% of patients have VTE risk assessment completed
over a Year without a serious incident in Theatres within the Division of Surgery
maintained 95% compliance with evidence based Surgical Site Infections Bundle
95% compliance with Salford Royal's Dementia and Delirium Care Bundle
97.9% of Salford Royal patients receive harm free care
90% of Salford Royal patients rate their care as excellent or very good
Best Trust nationally in the NHS Staff Survey 2013

Transparency

Require transparency about results, progress, aims, and defects

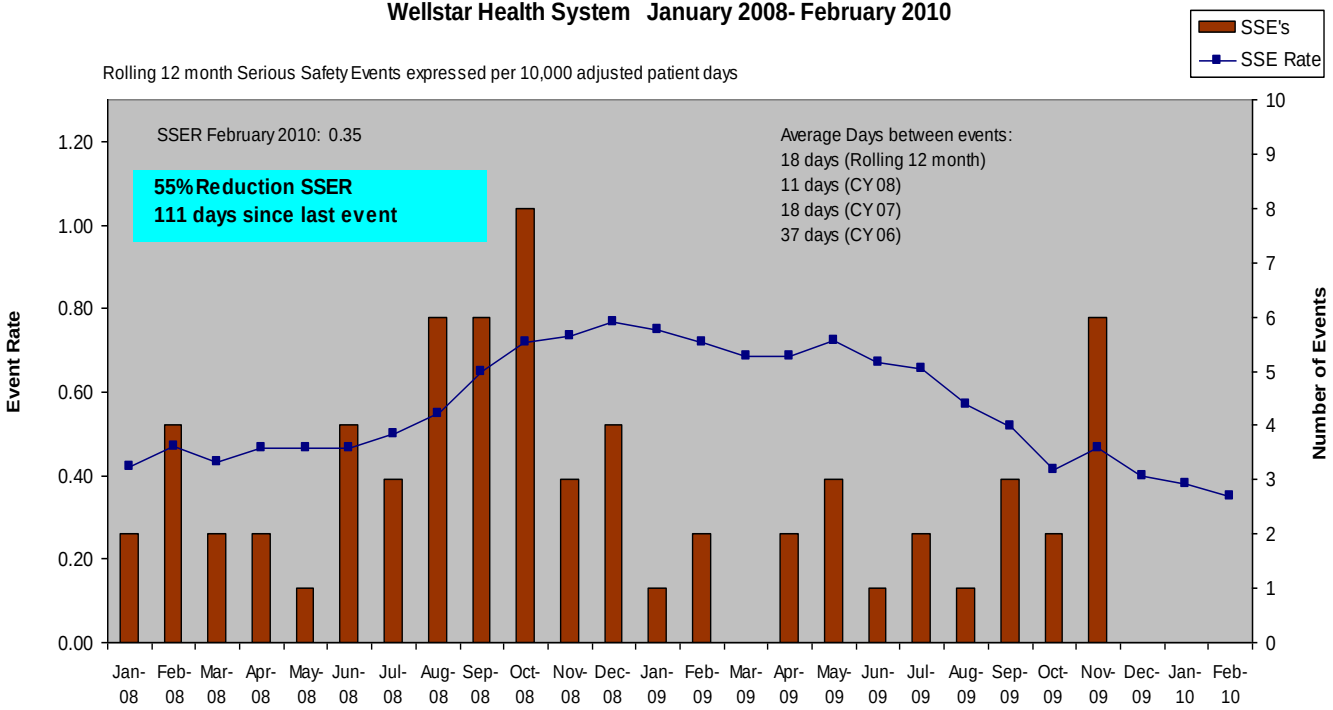
- Open reporting
- Display results
- Duty of candor

“If you display important results for everyone to see, you catalyze meaningful action. Patient results engage medical professionals; financial results do not.”

William C. Rupp, CEO Mayo Clinic Florida


Impact: over its fourteen years, the New York CABG surgery mortality reporting and quality improvement program has had a positive impact. Between 1989 and 1992 risk-adjusted mortality fell 41 percent statewide in New York
Chassin, Mark. Health Affairs. July/August 2002, Volume 21, Number 4, 40-51.
41% reduction in mortality

Serious Safety Event Rate
Wellstar Health System January 2008- February 2010



Medical Staff Leaders required mandatory Safety training for all 1700
All 11,000 employees trained as well

WELLSTAR

A different look at our baseline

John B.
9/06/2008
Delay in Dx

Shirley H.
12/23/08
Post Proced Death

Florita H.
7/03/2008
Delay in Tx

Wade W.
7/16/2008
Delay in Tx

Baby Boy S.
8/1/2008
Wrong Pt. Procedure

Joseph R.
9/08/2008
Delay in Dx.

Tamika M
4/21/2008
Med Error

Andrea M.
6/24/2008
Wrong Procedure

Nancy H.
6/18/2008
Med Error

Jimmy P.
7/07/2008
Fall

Joann E.
9/23/2008
Wrong Site Surgery

Cynthia M.
10/27/2008
Med Error

Regina D.
12/9/2008
Wrong Site Surgery

Baby Girl V.
5/12/2008
Mother's Delay in Tx

Kyle W.
9/13/2008
Delay in Tx

Teodur C.
1/29/08, 2/12/2008
Delay in Tx

Alvin G.
8/17/2008
Fall

Nicole S.
1/4/2008
Delay in Dx

Margaret H.
2/6/2008
Med Error

Ursula H.
2/12/2008
Fall

Ms. L.
2/14/2008
Delay in Tx

Sandra M.
12/10/2008
Post Procedure Death

Karen G.
8/5/2008
Proced Cx/Delay in Tx

Cynthia K.
11/10/2008
Delay in Tx

Lance D.
10/30/2008
Delay in Tx

Nicole H.
8/12/2008
Post-proced Cx

Robert S.
10/13/2008
Fall

Mary D.
3/9/2008
Med Error

Baby Boy G.
3/25/2008
Med Error

Lorena W.
11/10/2008
Post Procedure Death

Priscilla W.
8/30/2008
Delay in Tx

Dale W.
10/12/2008
Med Error

Eugene B.
10/27/2008, 10/28/2008
Med Error, Fall

Kathy W.
12/16/2008
Post Proced Loss of Function

Robert B.
12/2/2008
Post Procedure Death

Virginia L.
8/12/2008
Delay in Tx

Helene C.
9/5/2008
Fall

Lester J.
9/5/2008
Fall

Calvin P.
4/4/2008
Med Error

Gwendolyn P.
10/28/2008
Wrong Implant

Chantal E.
6/26/2008
Inapprop Touching

Gary B.
6/13/2008
Fall

Mary C.
12/19/2008
Fall

Douglas T.
10/18/2008
Med Error

WELLSTAR

Leading a 50% Reduction in events from baseline

Loueene D.
9/23/09
Fall

Beverly S.
2/4/09
Med Error

Robert D.
5/12/09
Post Procedure Death

Karen C.
9/28/09
Delay In Treatment

Peggy P.
7/1/09
Burn

Sharenda W.
2/15/09
Med Error

Edward R.
4/23/09
Wrong Side Procedure

Brenda R.
10/14/09
Delay In Treatment

James H.
10/25/09
Post Procedure Death

Lilliam C.
4/3/09
Retained foreign object

Dorothy R.
1/28/09
Delay In Treatment

Jerry Y.
11/7/09
Fall

Yoland C.
7/7/09
Delay in Treatment

Donna S.
6/4/09
Retained foreign object

Monroe K.
5/18/09
Post Procedure Death

Johnny B.
11/9/09
Fall

Alma M.
11/6/09
Fall

Scott G.
9/5/09
Delay in Treatment

Juanita A.
5/14/09
Delay In Treatment

Pauline M.
11/2/09
Fall

Rachel M.
11/3/09
Delay in Treatment

Michael F.
8/20/09
Retained foreign object

Willie B.
11/5/09
Med Error

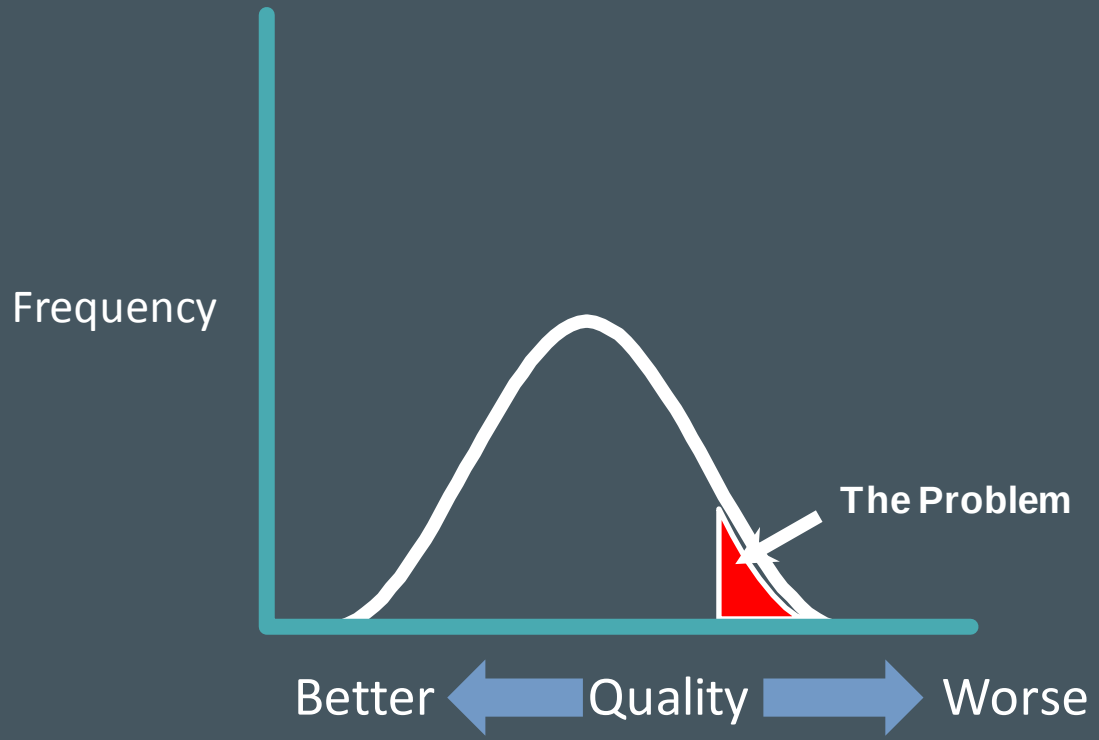
“The First Law of Improvement”

Every system is perfectly designed to achieve exactly the results it gets.

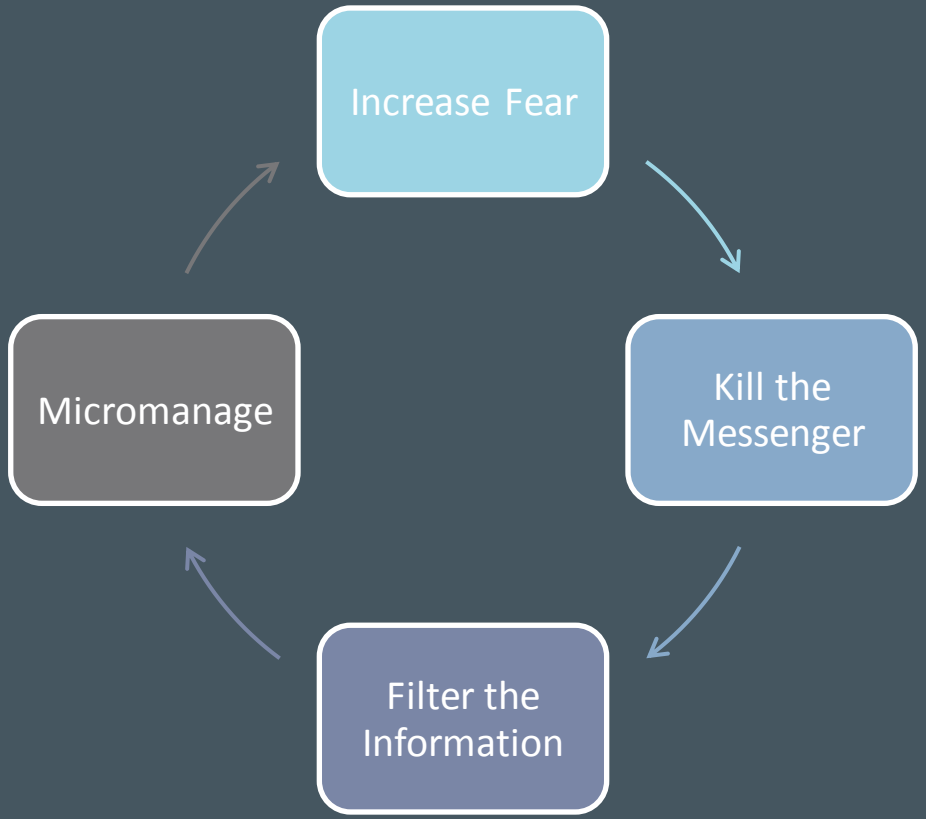
The simple, wrong answer

Blame somebody!

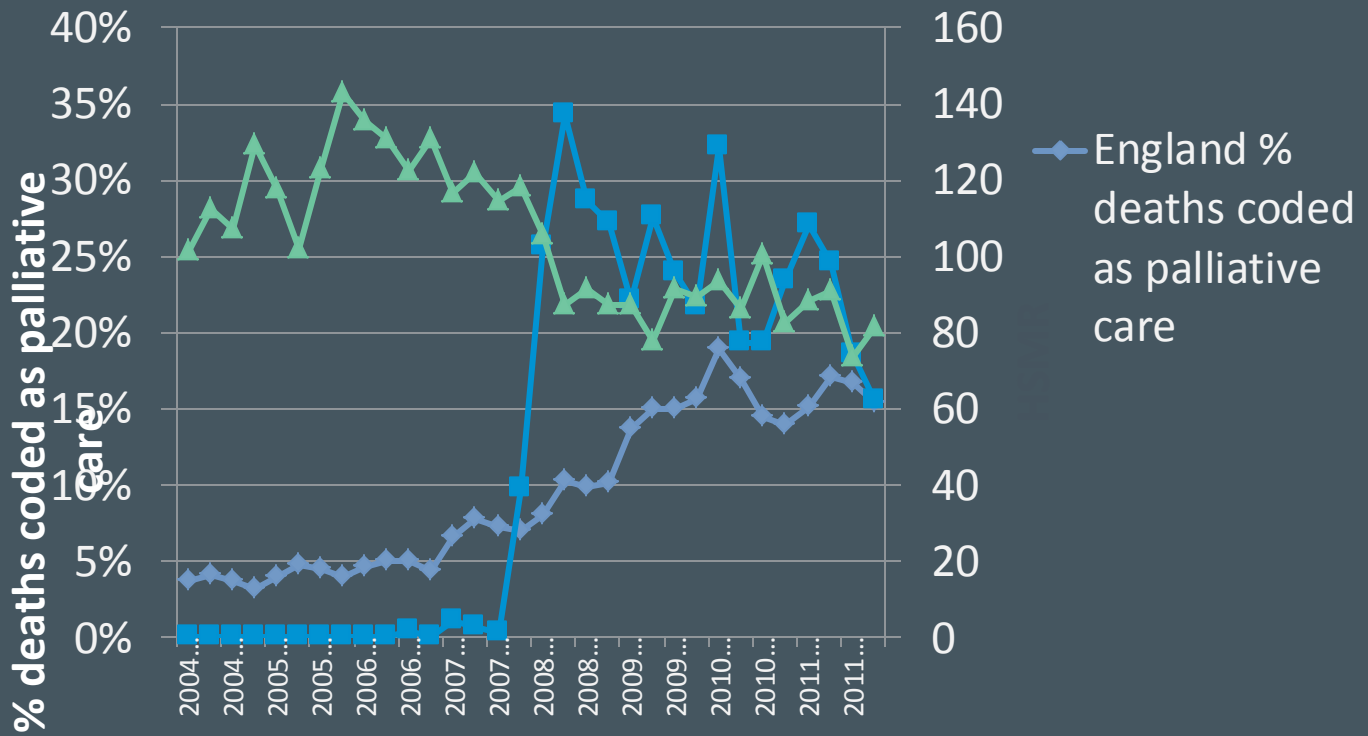
Answer #2 – Bad Apples



The Cycle of Fear



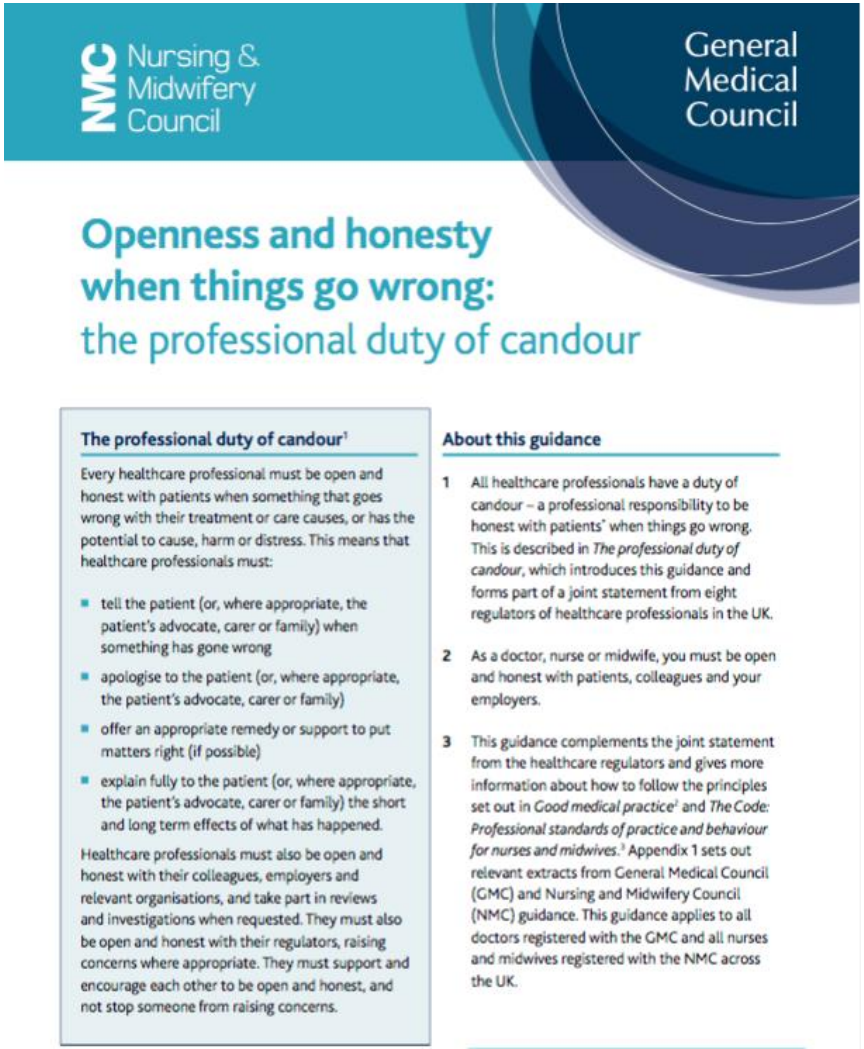
Mid Staffs coding of palliative care vs HSMR



Another way?

Old Way
(Quality Assurance)

New Way
(Quality Improvement)



NMC Nursing & Midwifery Council

General Medical Council

Openness and honesty when things go wrong: the professional duty of candour

The professional duty of candour[1]

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

About this guidance

1 All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients[2] when things go wrong. This is described in *The professional duty of candour*, which introduces this guidance and forms part of a joint statement from eight regulators of healthcare professionals in the UK.

2 As a doctor, nurse or midwife, you must be open and honest with patients, colleagues and your employers.

3 This guidance complements the joint statement from the healthcare regulators and gives more information about how to follow the principles set out in *Good medical practice*[2] and *The Code: Professional standards of practice and behaviour for nurses and midwives*.[3] Appendix 1 sets out relevant extracts from General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance. This guidance applies to all doctors registered with the GMC and all nurses and midwives registered with the NMC across the UK.

Boundarilessness

Encourage and practice systems thinking and collaboration across boundaries

Types of boundary

- Vertical – leading across levels, seniority, authority, power
- Horizontal – leading across functions, units, peer groups, areas of expertise
- Stakeholder – leading at interchange of organization, stakeholders, partners
- Demographic – leading between groups including the whole range of human of diversity
- Geographic – leading across distance, locations, cultures, and regions

Think of your silos – and break them down

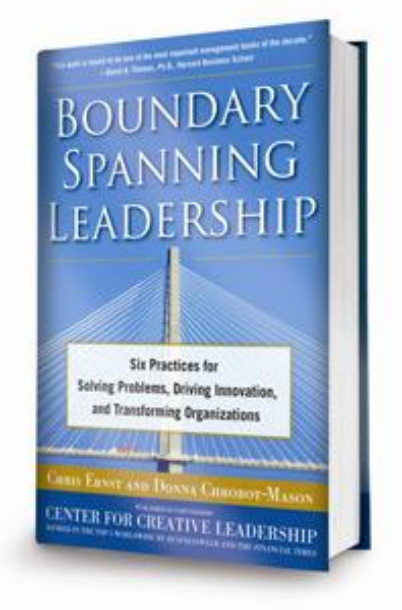
- Primary vs. secondary care
- Mental vs. physical health
- Planned vs. unscheduled care
- Medical vs. social care
- Nurses vs. doctors vs. therapists vs. social workers

The levels of leadership maturity

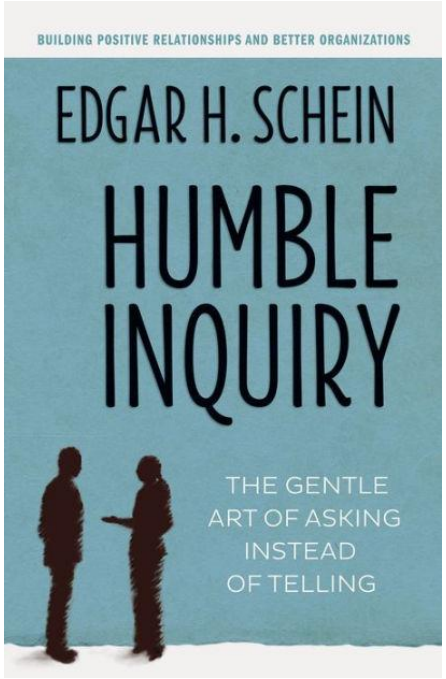
Descriptor	Level
10. Unitive	Post-Post-Conventional
9. Magician	Post-Conventional
8. Integrator	Post-Conventional
7. Individualist	Post-Conventional
6. Achiever	Conventional
5. Expert	Conventional
4. Conformist	Conventional
3. Self-serving	Pre-Conventional
2. Impulsive	Pre-Conventional
1. Undifferentiated	Pre-Conventional

Boundary spanning leadership

- Buffering – defines boundaries to create safety
- Reflecting – creates understanding of boundaries to foster respect
- Connecting – suspends boundaries to build trust
- Mobilizing – reframed boundaries to develop community
- Weaving – interlaces boundaries to advance interdependence
- Transforming – cross cuts boundaries to enable re-invention



Back to Edgar Schein



- Status, rank, and role boundaries as inhibitors
- Is deferential behavior always safe?
- What leadership behaviors will keep you informed?

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