20 YEARS PURSUING PERFECT CARE – DISAPPOINTMENT, SUCCESS, AND WHERE WE GO FROM HERE

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Michael Leonard, MD
Safe & Reliable Healthcare

2015 Hospital Quality Institute Conference, California
Our Discussion

• A framework to build a culture of safety, high reliability and continuous learning.
• Why understanding culture is essential, and how culture relates to habitual excellence or unnecessary variation.
• The role of leaders and teams in driving a Learning System.
• Specific, practical actions that can be taken to raise the bar and create value.
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• A framework to build a culture of safety, high reliability and continuous learning.

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• The role of leaders and teams in driving a Learning System.

• Specific, practical actions that can be taken to raise the bar and create value.
Success in Healthcare Going Forward

• Effective population health that delivers on the promise to the community.
• The ability to deliver safe and reliable care.
• Engaged patients and families – engaged caregivers.
• Systematic involvement of boards and senior leaders in engaging front line workers to help drive waste, harm and cost out of the system.
• Financial and operational stability.
Exercise

• You are assigned responsibility to evaluate a work setting in a healthcare organization.
  (Work Setting = Department, Division, Section – a delineated group working together)

• The unit is new to you.

• You are to evaluate the unit for its ability to achieve safe, reliable, person-centered operational excellence.

• What will you assess?
Optimal Care Requires a Learning System

- Safety is a characteristic of a **SocioTechnical system**
- System-level failures occur almost always because of unforeseen combinations of component failures
Socio-Technical Framework

People
• Leadership – senior & clinical, teamwork, psychological safety, human factors, organizational fairness, negotiation, engagement, resilience, communication

External
• Regulation, reporting requirements, competition

Workflow
• Normative actions: procedures, protocols, idea generation, learning, reliable processes, measurement, process improvement, transparency

Organization Values
• Goals, rules, accountabilities, focus

Technology
• Hardware, software, functionality, interactivity
People
- Leadership – senior & clinical, teamwork, psychological safety, human factors, organizational fairness, negotiation, engagement, resilience, communication

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Socio-Technical Maturity Model

- UNMINDFUL
  “We show up, don’t we?” Chronically Complacent

- REACTIVE
  “Safety is important. We do a lot every time we have an accident”

- SYSTEMATIC
  Systems in place to manage most defects

- PROACTIVE
  Systems to anticipate – prevent problems before they occur

- GENERATIVE
  Organizational hardwired for safety & improvement – in DNA

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Where is your organization?

Exercise
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COMMUNITY HOSPITALS

SOCIOTECHNICAL ASSESSMENTS: 7 DOMAINS IN 30 US HOSPITALS

Teamwork
Clinical Leaders
Senior Leaders
Psychological Safety
Organizational Fairness
Process Improvement
High Reliability
The SocioTechnical Framework is similar to another framework......

Organ Systems

Cardiovascular
Pulmonary
Gastrointestinal
Musculoskeletal
Etc
Characteristics of The High Performers

• Leadership was present 2-3 hours every day on the front lines engaged in meaningful dialogue with front line workers and patients.
• A coherent process to bring patients from primary care into the hospital.
• Medication reconciliation every time in the ED.
• Unit based hospitalists building relationships.
• Discharge planning began on admission.
• Detailed care coordination for the discharge.
SocioTechnical Framework

- Patient & Family Centered Care
- Leadership – Senior and Clinical
- Effective Teamwork
- Psychological Safety
- Organizational Fairness / Just Culture
- Reliable Processes of Care
- Learning System - Improvement
Why is Culture Important?

- Culture reflects the behaviors and beliefs within an organization.
- There are behaviors that create value individually, for the patient and the organization.
- There are behaviors that create unacceptable risk.
- These attitudes and behaviors are reflected in how people interact with each other both internally and externally with patients and their families.
- Culture is the social glue.
- Work as Imagined v. Work as Done.
### Culture in the real world

Unit-level culture survey data for a 400-bed hospital

<table>
<thead>
<tr>
<th>HCAHPS (Domain)</th>
<th>Teamwork % Positive Response</th>
<th>The Quality Chasm?</th>
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<tbody>
<tr>
<td>OB</td>
<td>57%</td>
<td>82%</td>
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<tr>
<td>ICU</td>
<td>5.7</td>
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<td>7W</td>
<td>15</td>
<td>60</td>
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<td>Geri</td>
<td>33%</td>
<td>75%</td>
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<td>2</td>
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<td>23%</td>
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<td>OR</td>
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**Source:** MIDAS / Statit, Real client data
Yes, but we’re different. **Really?**

Hospital-level culture survey data for a 13-hospital system

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<tr>
<th></th>
<th>H1</th>
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<td>Falls per 1000 days</td>
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<td>CLABSIs per 1000 days</td>
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**Every** organization’s culture links to its outcomes.

Source: MIDAS / Statit, Real client data
Culture metrics as early warnings

Yes. Culture predicts never events in the Operating Room.

Where would you rather work? Be operated on?

Psychological Safety
% Positive Response

Months between Wrong Site Surgeries or Retained Foreign Bodies

6 12 40

Source: MIDAS / Statit, Real client data
Our Discussion

• A framework to build a culture of safety, high reliability and continuous learning.

• **Why understanding culture is essential, and how culture relates to habitual excellence or unnecessary variation.**

• The role of leaders and teams in driving a Learning System.

• Specific, practical actions that can be taken to raise the bar and create value.
The Value of an Integrated Survey

• The SCORE survey measures important dimensions of organizational culture. It evolved from 20 years of experience with the Safety Attitudes Survey and a dozen years of experience with the AHRQ survey.

• Survey questions need to be both diagnostic and actionable.

• The insights are critical for organizational improvement and the ability to drive habitual excellence.

• Specific actions can be taken to leverage organizational strengths and address areas of fundamental opportunity.
SCORE Survey Domains

**Safety Culture**
- Learning Environment
- Local Leadership
- Resilience/Burnout
- Teamwork
- Safety Climate
- Work/Life Balance

**Engagement**
- *Job Demands*
- Job-related Uncertainty
- Intentions to Leave
- Workload
- *Resources*
- Growth Opportunities
- Participation in Decisions
- Advancement
What do “culture” surveys measure?

- Aspects of Culture
  - Teamwork within and across units
  - Supervisor and Manager expectations
  - Supervisor support of staff
  - Organizational learning
  - Psychological safety
  - Feedback
  - Frequency of event reporting
  - Handoffs and transitions
  - Non-punitive response to error
  - Working conditions
  - Stress recognition
  - Quality of leadership
  - Perceptions of safety
Learning Environment Questions

• In this work setting, the learning environment
  • is observable by the way we treat each other with respect.
  • utilizes input/suggestions from the people who work here.
  • integrates lessons learned from other work settings.
  • effectively fixes defects to improve the quality of what we do.
  • allows us to pause and reflect on what we do well.
  • is protected by our local management.
  • is valued by the people who work here.
Local Management/Leaders

• Local management/leader
  • is available at predictable times.
  • regularly makes time to provide positive feedback to me about how I am doing.
  • provides frequent feedback about my performance.
  • provides useful feedback about my performance.
  • provides meaningful feedback to people about their performance.
  • communicates their expectation to me about my performance.
Resilience/ Burnout Questions

• In this work setting people are
  • affected by events here in an emotionally unhealthy way.
  • burned out from their work.
  • exhausted from their work.
  • frustrated by their jobs.
  • working too hard on their jobs.
Teamwork Questions

• Disagreements in this work setting are appropriately resolved (i.e., not who is right but what is best for the patient).

• In this work setting, it is difficult to speak up if I perceive a problem with patient care.

• It is easy for personnel here to ask questions when there is something that they do not understand.

• The people here from different disciplines/backgrounds work together as a well-coordinated team.

• Dealing with difficult colleagues is consistently a challenging part of my job.
Safety Climate Questions

- My suggestions about quality would be acted upon if I expressed them to management.
- Errors are handled appropriately in this work setting.
- I receive appropriate feedback about my performance.
- The culture in this work setting makes it easy to learn from the errors of others.
- I would feel safe being treated here as a patient.
- In this work setting, it is difficult to discuss errors.
Work/Life Balance Questions

- Skipped a meal
- Ate a poorly balanced meal
- Changed personal/family plans because of work
- Had difficulty sleeping
- Slept less than 5 hours in a night
- Arrived home late from work
- Worked through a shift without any breaks
Safety Attitude Scores by Engagement Tier Level

- Average of TeamworkClimate: Tier I 80.8, Tier II 66.1, Tier III 52.7
- Average of SafetyClimate: Tier I 84.7, Tier II 72.4, Tier III 58.6
- Average of ThreatAwareness: Tier I 44.5, Tier II 47.8, Tier III 51.7
- Average of WorkLifeBalance: Tier I 56.5, Tier II 50.0, Tier III 45.0
- Average of JustClimate: Tier I 78.0, Tier II 61.0, Tier III 47.0
- Average of ResilienceClimate: Tier I 51.8, Tier II 40.9, Tier III 32.6

Courtesy Dr. Bryan Sexton, Duke University
Exercise

• Evaluate the culture survey data at your tables.

• What do you see?

• Where are the strengths and opportunities in this organization?

• What questions need further answering?
Our Discussion

• A framework to build a culture of safety, high reliability and continuous learning.
• Why understanding culture is essential, and how culture relates to habitual excellence or unnecessary variation.

**The role of leaders and teams in driving a Learning System.**

• Specific, practical actions that can be taken to raise the bar and create value.
Senior Leadership

- Cyclic flow of information with feedback and organizational learning
- Systematic engagement with dialogue, support and learning
- Process for interaction between senior leaders and front line staff
- They’re here – something bad must have happened
- We don’t know or see them
Safety Climate Domain

My suggestions about quality would be acted upon if I expressed them to management. (93)

In this work setting, it is difficult to discuss errors. (reversed) (93)

Errors are handled appropriately in this work setting. (93)

I would feel safe being treated here as a patient. (91)

I receive appropriate feedback about my performance. (91)

The culture in this work setting makes it easy to learn from the errors of others. (93)

Data: Feb 2015

Safe & Reliable Healthcare
The values of facility leadership are the same values that people in this work setting think are important.
Hospital Board And Management Practices Are Strongly Related To Hospital Performance On Clinical Quality Metrics

**ABSTRACT** National policies to improve health care quality have largely focused on clinical provider outcomes and, more recently, payment reform. Yet the association between hospital leadership and quality, although crucial to driving quality improvement, has not been explored in depth. We collected data from surveys of nationally representative groups of hospitals in the United States and England to examine the relationships among hospital boards, management practices of front-line managers, and the quality of care delivered. First, we found that hospitals with more effective management practices provided higher-quality care. Second, higher-rated hospital boards had superior performance by hospital management staff. Finally, we identified two signatures of high-performing hospital boards and management practice. Hospitals with boards that paid greater attention to clinical quality had management that better monitored quality performance. Similarly, we found that hospitals with boards that used clinical quality metrics more effectively had higher performance by hospital management staff on target setting and operations. These findings help increase understanding of the dynamics among boards, front-line management, and quality of care and could provide new targets for improving care delivery.
Daily Operational Brief – DOB

• 15-20 minutes every morning with all departments represented to get the broad picture of what is happening in the hospital, the constraints and resources that can be brought to bear.

• It gets everyone on the same page.

• Having the big picture allows people to be more proactive.

• Subsequent surprises occurring during the day can be debriefed the following morning to promote learning.

• Everybody talks, it is structured and efficient.
Why a Learning System is Essential

• You have really good people working in an environment that does not optimally support their efforts.
• Lots of first order problem solving in healthcare.
• We are generally not very good at process improvement.
• 30% of healthcare spending does not create value – lots of waste, harm and defects = opportunity.
• Constant defects and workarounds are frustrating and demoralizing.
Why hospitals don't learn from failures:

Organizational and psychological dynamics that inhibit system change

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Harvard Business School
Morgan Hall
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Boston, MA 02163

November 6, 2002
Effective Leadership Practices

• Regularly scheduled, dedicated time to engage with front line workers.
• Structured dialogue that relates to work they do and the opportunity to raise the bar.
• Reinforcing the good work they do and how it aligns with the goals of the organization.
• Having the dialogue in front of the Learning Boards so it drives learning and increases the visibility of improvement efforts.
• Tracking what was discussed and improved so feedback is supported.
Leadership Walkrounds - Why is it Hard?

- Many competing interests.
- I may not have domain expertise and feel uncomfortable in clinical areas.
- I don’t want to look incompetent.
- There are many challenges and we have limited resources to fix them.
- Front line caregivers may raise difficult issues we can’t fix.
'I think we should just listen and get out': a qualitative exploration of views and experiences of Patient Safety Walkrounds

Leahora Rotteau, Kaveh G Shojania, Fiona Webster

ABSTRACT
Objective This article is an exploration of views and experiences of Patient Safety Walkrounds, a widely recommended strategy for identifying patient safety problems and improving safety culture.
Design and setting Qualitative analysis of semistructured, in-depth interviews with 11 senior leaders and 33 front-line staff at two major teaching hospitals with mature walkrounds programmes, collected as part of a larger mixed-methods evaluation.
Results Despite differences in the structure of the two walkrounds programmes, senior leaders at both institutions reported attitudes and behaviours that contradict the stated goals and principles of walkrounds. Senior leaders tended to regard executive visibility as an end in itself and generally did not engage with staff.

BACKGROUND
Patient Safety Walkrounds, also known as Executive Walkrounds or Leadership Walkrounds, has emerged as a promising strategy for identifying specific patient safety problems and, more generally, improving safety culture. Though details vary across institutions, walkrounds typically involve senior leaders meeting with front-line staff to discuss patient safety concerns, in a forum that is intended to be open and blame-free. These concerns may range from practical issues (eg, equipment availability or functionality) to deeper challenges (eg, adequacy of staffing or inter-professional communication problems). Based on the open, non-hierarchical nature of the conversations,
Nominal Respect

I’m not in the frontlines, I’m not experienced. You have to walk the shoes to understand what’s going on. (Senior leader 3, Hospital 2)

However, on further reflection about his experience participating in the walkrounds, he contradicted this characterisation of front-line staff as experts from whom senior leaders could learn.

The truth of the matter is I won’t learn that much new because I sort of know what’s going on. I know all the barnacles, I know what we need, I know what we don’t have...I don’t go there to learn that much anymore. (Senior leader 3, Hospital 2)
Executive Presence without Engagement

I think the main purpose was to demonstrate senior management leadership and commitment to patient safety. (Senior leader 5, Hospital 2)

But ...from the vantage point of trying to be leaders of influence... trying to push it down into the organization that we’re serious about this [patient safety]... we needed to put our weight behind it. (Senior leader 4, Hospital 1)

However, one senior leader acknowledged wanting to appear interested for the benefit of the front-line staff rather than actually being interested.
I spend a lot of time trying to set out almost the terms of engagement by saying, “this is what we want to talk about specifically”. (Senior leader 2, Hospital 1)

So immediately one of them [frontline staff] says what we really need here is ...extra nurses at night. So I’ll say, well, you know what, I’m going to bring you back because I want to remind you that what we’re really trying to identify here are some areas where I can actually deliver for you in a short period of time. And I’ll acknowledge the fact that they’ve got staff and other issues. But there’s times where we just need to move on. There’s no value in us spending an hour talking about that. (Senior leader 5, Hospital 1)

Two of the senior leaders also noted the importance they placed on front-line staff maintaining a professional atmosphere.

I’m a little controlling in a sense that if I see it’s getting too negative and it’s losing its productivity or constructivity (sic)...Because it begins to pollute the air...I like professional environments. (Senior leader 3, Hospital 2)
Engagement SCORE Domains by WalkRounds

Mean of the clinical area scores

- Advancement, 15
- Growth Opportunities, 52
- Job Certainty, 70
- Local Leadership, 69
- Pt in Decision Making, 55
- Workload, 43

MI 2015 (n=16,797)
EWR FB Yes (n=4074)
EWR FB No (n=5598)
The Ideal Unit
Clinical Leadership

**GENERATIVE**
Organization wired for safety and improvement

**PROACTIVE**
Playing offense - thinking ahead, anticipating, solving problems

**SYSTEMATIC**
Systems in place to manage hazards

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture

- Leaders create high degrees of psych safety and accountability.
- Leaders model the desired behaviors to drive culture of safety.
- Training and support exists for building clinical leadership.
- Episodic, completely dependent on the individual clinician.
- Absent for the most part.

Safe & Reliable Healthcare
Local Leadership Domain

In this work setting, local leadership...

- ...is available at predictable times. (1012)
- ...communicates their expectations to me about my performance. (1005)
- ...provides meaningful feedback to people about their performance. (1007)
- ...provides useful feedback about my performance. (1007)
- ...provides frequent feedback about my performance. (1007)
- ...regularly makes time to provide positive feedback to me about how I am doing. (1014)
- ...regularly makes time to pause and reflect with me about my work. (1012)
Major article

Nurse staffing, burnout, and health care—associated infection

Jeannie P. Cimiotti DNSc, RN\textsuperscript{a,b,*}, Linda H. Aiken PhD\textsuperscript{c}, Douglas M. Sloane PhD\textsuperscript{c}, Evan S. Wu BS\textsuperscript{c}

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\textsuperscript{b}College of Nursing, Rutgers, The State University of New Jersey, Newark, NJ
\textsuperscript{c}Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, PA

Key Words: Hospital Workload Cost PHC4

\textbf{Background:} Each year, nearly 7 million hospitalized patients acquire infections while being treated for other conditions. Nurse staffing has been implicated in the spread of infection within hospitals, yet little evidence is available to explain this association.

\textbf{Methods:} We linked nurse survey data to the Pennsylvania Health Care Cost Containment Council report on hospital infections and the American Hospital Association Annual Survey. We examined urinary tract and surgical site infection, the most prevalent infections reported and those likely to be acquired on any unit within a hospital. Linear regression was used to estimate the effect of nurse and hospital characteristics on health care–associated infections.

\textbf{Results:} There was a significant association between patient-to-nurse ratio and urinary tract infection (0.86; \(P = .02\)) and surgical site infection (0.93; \(P = .04\)). In a multivariate model controlling for patient severity and nurse and hospital characteristics, only nurse burnout remained significantly associated with urinary tract infection (0.82; \(P = .03\)) and surgical site infection (1.56; \(P < .01\)) infection. Hospitals in which burnout was reduced by 30\% had a total of 6,239 fewer infections, for an annual cost saving of up to $68 million.

\textbf{Conclusions:} We provide a plausible explanation for the association between nurse staffing and health care–associated infections. Reducing burnout in registered nurses is a promising strategy to help control infections in acute care facilities.
Psychological Safety

- Primary responsibility of leaders, continuously modeled everywhere.
- Leaders model and expect the behaviors that promote psychological safety.
- In some units it feels safe to speak up and voice a concern.
- Personality dependent – it depends with whom I’m working.
- Fear based – keep your head down and stay out of trouble.
In this work setting, it is not difficult to speak up if I perceive a problem with patient care.
We are our own image consultants and best image protectors.

To protect one’s image, if you don’t want to look:
- Stupid
- Incompetent
- Negative
- Disruptive

To protect one’s image, you must:
- Don’t ask questions
- Don’t ask for feedback
- Don’t be doubtful or criticize
- Don’t suggest innovations

Psychological Safety
Psychological Safety

UNMINDFUL
“We show up, don’t we?” Chronically Complacent

REACTIVE
“Safety is important. We do a lot every time we have an accident”

SYSTEMATIC
Systems are in place to manage most defects

PROACTIVE
Systems to anticipate – prevent problems before they occur

GENERATIVE
Organizational hardwired for safety & improvement – in DNA

- ask questions
- ask for feedback
- be doubtful or criticize
- suggest innovations
To protect one’s image, if you don’t want to look stupid, incompetent, negative, ask questions. Be doubtful or criticize. Ask for feedback. Suggest innovations.

PROACTIVE
Systems to anticipate – prevent problems before they occur

SYSTEMATIC
Systems are in place to manage most defects

REACTIVE
“We safety is important. We do a lot every time we have an accident”

GENERATIVE
Organizational hardwired for safety & improvement – in DNA

UNMINDFUL
“We show up, don’t we?” Chronically Complacent

Psychological Safety
Psychological Safety

To protect one’s image, if you don’t want to look stupid, incompetent, negative, disruptive.

GENERATIVE
Organizational hardwired for safety & improvement – in DNA

UNMINDFUL
“We show up, don’t we?” Chronically Complacent

Safe & Reliable Healthcare

ask questions.
ask for feedback.
be doubtful or criticize.
suggest innovations.
The Journey
The Journey
The Path
Cultures catapult from mediocrity into excellence when all the components come together because only then do they grapple with thorny issues.
Effective Teamwork

**GENERATIVE**
Organization wired for safety and improvement

**PROACTIVE**
Playing offense - thinking ahead, anticipating, solving problems

**SYSTEMATIC**
Systems in place to manage hazards

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture

- Teamwork and continuous learning deeply embedded and central to our culture.
- Teamwork methodically taught and modeled across the organization.
- Training and tools available, partial implementation.
- Focus on teamwork awareness / training in response to adverse events.
- If people would just do their jobs we’d have no problems.
Teams

- **WHAT TEAMS DO:**
  - Plan Forward
  - Reflect Back
  - Communicate Clearly
  - Manage Conflict

The associated behaviors:

- Brief (huddle, pause, timeout, check-in)
- Debrief
- Structured Communication SBAR and Repeat-Back
- Critical Language

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Teamwork Videos – Observing behaviors
## Observation Sheet

### Behaviors

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Rate usage of special behaviors.</th>
<th>Descriptive Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Ineffective ← ← ← ← Very Effective</td>
<td></td>
</tr>
<tr>
<td>Briefing</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Inquiry &amp; Rebriefing</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Assertion &amp; Challenge</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Structured Communication</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Closing the Loop</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Debriefing</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

### Behaviors Guidelines

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
<th>Rating = 1 Examples</th>
<th>Rating = 2 Examples</th>
<th>Rating = 3 Examples</th>
<th>Rating = 4 Examples</th>
<th>Rating = 5 Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefing &amp; Rebriefing</td>
<td>Formal task/actions briefing at the start of a procedure. Formal / distinct re-briefing when conditions change in the midst of a procedure.</td>
<td>Formal briefing does not occur when appropriate (e.g., start) Lack of game plan and discussions</td>
<td>Formal briefing is disorganized Components of formal briefing are incomplete Game plan is not always clear to all.</td>
<td>Names/roles &amp; procedure verified All know game plan Details, critical steps &amp; possible problems raised &amp; re-addressed</td>
<td>Importance of briefing emphasized All know the game plan all the time</td>
<td>Looks good All components seen Want to take a video</td>
</tr>
<tr>
<td>Closing the Loop</td>
<td>Confirmation that information was received by repeating the content of the information back to the sender (i.e., read back and hear back).</td>
<td>Requests, orders &amp; instructions never repeated Information is confused</td>
<td>Requests, orders, &amp; instructions seldom repeated even though it is pertinent</td>
<td>Pertinent requests, orders &amp; instructions are repeated back to the sender when recev'd</td>
<td>In addition to closing the loop, members note its importance</td>
<td>Looks good All components seen Want to take a video</td>
</tr>
<tr>
<td>Debriefing</td>
<td>Formal debriefing following a procedure that covers what went well, what went not so well, and what might be done differently in the future.</td>
<td>Debriefing does not occur when appropriate (e.g., end of procedure)</td>
<td>Debriefing does not cover relevant questions Debriefing does not yield clear takeaways</td>
<td>Debriefing held at end of procedure Debriefing generates clear takeaways</td>
<td>Debriefing exceptionally structured Members comment on importance of debriefing</td>
<td>Looks good All components seen Want to take a video</td>
</tr>
</tbody>
</table>
Our Discussion

- A framework to build a culture of safety, high reliability and continuous learning.
- Why understanding culture is essential, and how culture relates to habitual excellence or unnecessary variation.
- The role of leaders and teams in driving a Learning System.
- **Specific, practical actions that can be taken to raise the bar and create value.**
Three Rounds Exercise

What key activities HAVE YOU EXPERIENCED that help work settings become excellently safe and reliable (in or out of healthcare)?

What are key activities or attributes YOU HAVE EXPERIENCED that help work settings maintain safe and reliable operational excellence (in or out of healthcare)?

The Process: 3 rounds of discussion, each for 8 minutes, with 3 different individuals
  • Speak to someone you DON’T know.
  • Introduce yourselves.
  • Build on, and combine your insights, in each consecutive round.
Learning System

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</tr>
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</table>

- Unit level learning systems, continuous learning aligned with organizational goals.
- Robust unit level learning and improvement is the norm.
- Knowledge of testing, process improvement, collaborative work.
- We try harder after process failures or adverse events.
- Lots of first order problem solving, simple things don’t get fixed.

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Learning Environment Domain

In this work setting, the learning environment...

- Utilizes input/suggestions from the people that work here. (1015)
- Is protected by our local management. (1008)
- Integrates lessons learned from other work settings. (1011)
- Allows us to pause and reflect on what we do well. (1012)
- Effectively fixes defects to improve the quality of what we do. (1012)
- Allows us to gain important insights into what we do well.
In this work setting, the learning environment effectively fixes defects to improve the quality of what we do.
Debriefing – Linking teamwork and Improvement

• What did we do well?
• What did we learn so we can do it better the next time?
• What got in the way that needs to be fixed?
The Ideal Unit
Acute Medicines Unit, Ninewells Hospital, Dundee, Scotland
Arun Chaudhur, Medical Director

O2 Prescribing
DVT Prescribing Compliance
Compliance with Med. Reconciliation

SNAP-CAP
ABX Prescribing Compliance
Blood Culture Contamination

Early Warning Scores Bundle
Pressure Ulcer Prevention Bundle
Hand Hygiene

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The Defect or Learning Board

Total Number of Defects: 117
% of Defects Completed: 43%
% Of Defects In Progress: 41%
% of Defects Not in Progress: 11%
Defects without movement in >30 Day: 33
Defects without movement in >60 Day: 27

© Mercy Medical Center 2010 ‘Turtle Board’
Lessons from hospitals that are winning

1. Better Assessment
2. Getting Engaged Leaders to Commit
3. Building the Team
4. Connecting Leaders and the Frontline
5. Embed

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