Leading a Patient Safety Culture:

Beyond Scores and Stats

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Abstract

The ever increasing demands of leadership have not allowed today's leaders the luxury of time needed to step back and look at the 'big picture'. The biggest failure of all has proven to be the most critical: a failure of perception. Culture has repeatedly been identified as the greatest barrier to patient safety (IHI). What is this phenomenon that travels as a powerful undercurrent in organizations? And how can leaders' un-mine and control an invisible force?

Using Professor Diamond's framework (Collapse), for "How group decisions fail", this presentation offers a fresh and fascinating look at the hospital safety culture in light of sociology. Patient safety can never be achieved as a top-down driven initiative. Safety is a core value. In this session, leaders will learn how to identify their culture beyond the statistics and sustain the value system and behaviors critical to keeping our patients safe.

Objectives

- List three reasons why groups fail at decision making
- Discuss the impact of perception on patient safety and quality care
- Identify and apply two major concepts that would provide perspective and power to leadership
- Understand how to maximize power and resources within a human institution.
- Describe two specific actions that you personally can adopt now to lead a patient safety culture.

Flight Plan for Patient Centric Care

From "Charting the Course: Launching Patient Centric Care"
By John Nance and Kathleen Bartholomew

Potential structures:

A. Mandatory weekly rounding by all leaders and managers, and full-shift periodic rounding by board members.

* Education on <u>meaningful</u> rounding, philosophy, and building trusting relationships.

Survey the culture to ensure the same rules apply to everyone. Only when vision, values and behaviors match, can true cultural change begin.

* Do not pursue Just Culture until the same rules apply to all roles.
* Flatten the hierarchy by following front line staff, inviting them to follow you, sharing

meals, asking for feedback and 360 degree surveys

* Ask the right question: *Can anyone do surgery on your mom? Can any nurse take care of your loved one?*

B. Harmonize medical staff by-laws with the corporate bylaws; and include identical behavioral standards in annual performance evaluations.

* Never abandon a team member in the case of an adverse occurrence. Support each other through full and open discussion of truth. Sanction or remove those who abandon their team or team leader by misrepresentation, refuse to share all available information, or attempt to elicit blame and shame after an adverse occurrence.

C. Provide <u>continuous, repetitive education and recurrent</u> **Team Training** (creating a Collegial Interactive Team/Leading a Collegial Interactive Team) conducted by different sources both internal and external to organization: Invite folks from other industries, and share success stories publicly.

1. Use videoed "empty-room simulation" for team training, and as soon as possible begin training facilitators
2. Provide on-line educational tools and resources. Require annual team evaluation.
3. <u>Measure</u> communication competency

D. Elicit deep-thought ideas from the front lines in all departments on how to solve problems and address challenges by setting up informal membership (no empire building) advisory groups, continuous engagement, and rolling discussion; and shepherd mid-level managers and directors into a facilitator role after coaching education.

E. Physician-Nurse Engagement. Minimum of 6-8 physicians and nurses to meet monthly in every department. The guiding principle: No time together = no improvement.

1. Provide education to the group on the history and culture of MD/RN relationships.
2. Dyad Model of leadership (Physician/Nurse leader working partnership)
3. Nurse-Physician Council – bi annually
4. Nurse-Physician Summit. (Compact)
   - Have MD's and RN's share last medical error as opener – (evens playing field).
   - Describe the current MD/RN norms – create a new set of norms together
   - Invest in fostering, nurturing and maintaining collegial MD/RN relationships

F. Hardwire safety huddles per department and inter-department to answer the following:

1. Where will our next patient safety disaster or near-disaster come from?

2. What steps should we take to immediately address and improve person-to-person communication and establish relationships across silos?

3. Make harm visible. Every employee should be able to tell the story of how the last adverse event occurred, and the improvement put in place to prevent further harm

E. Design and launch a continuous effort to support on-going education on communications and relationships: **culture change focus must be on language and behavior**

1) Increase non-productive budget and educational budget for on-going staff and leadership development.
2) Results must be visible and gains shared to maintain the momentum.
3) Hardwire support for relationships issues which are sure to arise when you change a culture….Employee Education?
4) Physician Leadership Institute – e.g. Salem Hospital's ongoing program which results in physicians leading an interdepartmental improvement project.

G. Establish and invite widespread participation in monthly facilitated "think tanks". Indicator of success will be that group is multi-level and hard-wired into culture
    - e.g. Re-designing nursing to increase time at the bedside vs. non nursing tasks
    - e.g. Providing time and space for all departments to address issues
    - e.g. Stimulate informal conversation by changing cafeteria to all round tables

Suggested Reading:

Frankel A., Leonard, M. and Denham, C., Fair and Just Culture, Team Behavior and Leadership Engagement: The Tools to Achieve High Reliability. Health Services Research, 2006 August; 41; 1690-1709

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Pentland, A. (2012) The new science of building great teams. Harvard Business Review. April, 2012

Sammer, C. et al., What is a Patient Safety Culture? A Review of the Literature. Journal of Nursing Scholarship, 2010, 42:2, 156-165

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