Engaging Leadership in Patient Safety and Quality

J. Bryan Sexton, PhD
Associate Professor, Department of Psychiatry
Director of Patient Safety Center, Duke University Health System

www.dukepatientsafetycenter.com

Webinars:
- Jul 20, 2010: Safety Culture 101: Work with Culture Data
- Aug 10, 2010: Psychological Safety
- Sep 8, 2010: Leadership Engagement in Quality & Patient Safety
- Oct 6, 2010: Intro to Safety: Culture Debriefings
- Nov 3, 2010: Stress Recognition and Coaching
- Dec 8, 2010: Finding, Fixing and Learning from Defects
- Jan 12, 2011: Introduction to TeamSTEPPS
- Mar 3, 2011: Caregiver Resilience and Quality Improvement: Double Edged Sword
- Apr 13, 2011: Fatigue Management
- May 18, 2011: Conflict Resolution
- Jun 8, 2011: Care Coordination and Handoffs
- Jul 13, 2011: Advanced RCAs

Courses:
- Patient Safety Leadership Training (3 days - Offered in April & September)
  - Course Description
  - Registration Information, August 2011
  - Registration Information, September 2011
- TeamSTEPPS Implementation: Train the Trainer (2 days)
  - Course Description
- Enhancing Caregiver Resilience: Burnout & Quality Improvement Full Course
  - 3 days, 1 full day plus 2 half days, and a follow-up webinar - Offered in May & November
  - Course Description
  - Registration Information, November 2011
  - Registration Information, May 2012
- Registration Information, November 2012

For Registration Information:
Please contact Christen Fullwood at 919-257-3376

Calendar of Courses: For additional information or to request dates and times of training, please call 919-257-3376 or email christen.fullwood@duke.edu
Executive Partnerships I: Introduction and Background

Learning Objectives

- To review the history and evolution of executive partnerships, with a focus on relevant data and best practices
- To learn Adaptive Leadership, Psychological Safety
- To understand the nuances of an executive visit: framing the issues, pacing the change, setting the expectations and accountability
Background of WalkRounds

• Clarification of terms: Leadership Rounds, Executive WalkRounds™, Executive Adopt a Unit, and Senior Leader and Unit Partnerships… also a component of CUSP

• Dr. Allan Frankel invented the concept at the Brigham, whereby VPs (or higher) would visit random clinical areas once a month throughout the hospital.

• Peter Pronovost adapted the concept so that a specific senior leader would partner with a specific unit, form a mutual rapport, and create a new patient safety infrastructure within the clinical area.

Goals of Executive Safety Partnerships

• Near Term Goal: to build capacity for quality improvement within the unit

• Medium Term Goal: to have staff bring up solutions rather than problems

• Long Term Goal: for staff to say:
  – “We don’t need to meet monthly with the executive”
  – “I would feel safe being treated here as a patient”
  – “I felt like I was heard today”
  – “I made a difference today”
Executive Safety Partnerships: Essentials for Sustainability

- Monthly
- Use of unit based safety officer
- Trained executive/safety officer
- Targets 60% of staff participating at least once
- Master Learning from Defects Tool:
  - Objective is psychological safety & empowerment of staff
  - Classifies issues as technical vs. adaptive
  - No more than 2 action plans generated per visit
  - Accountability through timelines and appropriate pace
The Executive/Unit Based Safety Officer
– Inspiration, direction, vision, urgency …
– Processes, resources and support

From the front line:
– Action, concrete changes, experiments
– Ideas and suggestions
Executive Partner:

Best candidate for EP – research still ongoing:
- Comfortable walking through clinical areas and discussing complicated problems
  - High tolerance for ambiguity (not afraid of the grey areas)
  - Puts others at ease/Approachable
  - Pulls others out of their shells/Positive reinforcement
- Skilled at sharing and using operational perspective to remove barriers encountered by staff
- Balances the need for building quality improvement capacity of the unit with learning opportunities and solving problems
- Typically VP or higher (but this is historical trend rather than evidence based)

Unit Based Safety Officer:

Basic Characteristics

Organized/Responsible
Good communicator/trusted by staff

- Oftentimes, the best candidate is:
  - Masters prepared nurse
  - Nurse educator/Research nurse/Magnet Ambassador
  - Staff member with quality & safety fire in their belly (frequent flyer on your incident reporting system)
  - Connects well with younger and more senior staff, as well as unit manager
Unit Based Safety Officer

• Quality and safety “ambassador” representing the unit, and the bridge to the Executive Partner
  – (may be most unique role, anticipate objections and questions)
• Collects data
• Tracks task completion
• Communication hub
• Local “face” of the partnership

Preparing a unit for Executive Safety Partnerships

The goal is to have staff bring up solutions rather than problems; provide them with the tools and perspectives that they need to be effective stewards of care quality in their clinical area.

- Safety as a System: A Perspective from the Bottom-up
  • 28 Minute online course
  • www.dukepatientsafetycenter.com
- Learning From Defects
Learning from 1 Defect / Month

- Pick a Defect
- Answer
  - What happened
  - Why did it happen
  - What can we do to reduce the risk of it recurring (esp. with different caregivers)
  - How will we know risks were reduced
  - With whom should we share lessons learned

ADAPTED FROM:
-and-
Primer on Leadership Strategies

Many of the strategies covered here are directly attributable to Dr. Ron Heifetz, Director of the Leadership Education Project at the John F. Kennedy School of Government, Harvard.

Leadership is...

Getting groups of people to do things that make the world a better place
Leadership is not...

- **Usurpation of power**
  - If you threaten the legitimacy of unit manager, you are doing this incorrectly
  - You are here to help, because the hospital failed to provide the support, resources, or attention span to this unit in the past

Framing for Learning

**Effective implementers frame change as:**
- motivated by aspiration rather than by a defense against threat
- a team learning project rather than as individual skill acquisition
- an organizational challenge rather than a technical challenge.

**Facilitate shared urgency, not private fear:**
- The learning frame consists of aspirational goals, an emphasis on collaborative teamwork, and a distinct blend of mutual respect and humility
Adaptive Work

<table>
<thead>
<tr>
<th>Kind of Work Needed</th>
<th>Problem Definition</th>
<th>Solution and Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td>Clear</td>
<td>Clear</td>
</tr>
<tr>
<td>Technical/Adaptive</td>
<td>Clear</td>
<td>Requires Learning</td>
</tr>
<tr>
<td>Adaptive</td>
<td>Requires Learning</td>
<td>Requires Learning</td>
</tr>
</tbody>
</table>

-adapted from Heifetz, 2003, Table 1, page 76

Help frontline staff to participate in ways that are rewarding, validating, and empowering

- **Prioritize**: 1 or 2 issues that are achievable but challenging, engage their insight into what a reasonable timeframe is to expect an update on progress.
- **Predictable**: visits are announced in advance
Help frontline staff to participate in ways that are rewarding, validating, and empowering

- **Engage**: Rather than answer questions, ask them what they think first, pull them out of their shells, and note thoughtful contributions (build confidence and ownership).
- **Sustain**: Staff involved in the surfacing of safety concerns should be invited to participate in solutions and be the first notified of success.

**Triage Concepts:**

**Pace and Engagement**

- Pace the work at a rate they can stand, frequent mistakes:
  - Too many issues are surfaced too quickly
  - Delayed/No feedback on progress
  - No positive reinforcement for participation
  - Not frequent enough
  - Executive stops coming

- One round should generate no more than 2 action plans, only one of which should be adaptive
  - If easy technical fixes addressed too quickly, adaptive changes that are left over become overly daunting
**Worst Practices: Scope Creep**

- Scope Creep: Beware that the concept of patient safety/quality does not get confused with patient satisfaction or other seemingly similar concepts – this is how partnerships quickly lose focus and wither
- This is about respecting local wisdom in this unit – NOT about giving local manager a vehicle to meet regulatory requirements…

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**Fear of the Dreaded “We need more staff” issue:**

How to address this as an adaptive change…
- Ask questions to understand how this impacts staff
  - Staffing levels and perceptions of staffing levels are not the same
- Consider it to be a defect, ask them to conduct a learning from defects session
- Use tools to standardize interactions (remove some of the chaos) such as morning briefing/daily goals as bridge solutions
Best Practices: Golden Questions

• Questions:
  – “How will the next patient in this unit be harmed?”
  – “How can I help to remove barriers, so that the safety defects you are most concerned about can be better addressed?”
  – “What doesn’t work well?”
  – “Do some Ethnic groups get better care here than others?”
  – “How well does teamwork occur on this unit?”

Executive Safety Partnership Cheat Sheet

Adapted from:
Thomas et al. BMC Health Serv Res. 2005; Jun 8;5 (1)
-and-
Executive Safety Partnerships

Objective
Remove barriers, enhance trust so their issues are surfaced and addressed, allow learning and improvement with a local ownership of this process (i.e., “not here to blame or audit”).

STRATEGIES (to surface barriers):
Review recent incident reports, infections, complications, safety culture results; were Culture Checkup Tool actions taken? Learning from Defects tool issues: What happened, Why did it happen, what have you done to reduce the likelihood of it recurring with different caregivers, how will you know risk was reduced, and with whom did you share the lessons learned? Follow up on actions to address issues from previous visits.

SAMPLE QUESTIONS:
“Who will be the next in this clinical area be harmed?”
“Was a patient recently harmed because of less-than-safe care?”
“Where can we do a regular basis to improve safety?”

Evidence shows that the % of caregivers exposed to rounds over time should be maximized (via # rounds & connecting with different caregivers each visit).

Executive Safety Partnerships

Executive Safety Partnerships Fast Facts:

What do I need to know?
Monthly executive partnerships whereby the same executive visits the same unit (1 hr), serve to build local ownership, trust and capacity for ongoing quality improvement. Encourage and reward staff for innovation and questioning the status quo. When combined with monthly use of the Learning from Defects tool, these partnerships are most productive over time, the need for the executive decreases as staff comfort with defect tool increases.

What do I need to do?
Executive (e.g., VP or higher) works with unit-based safety officer to schedule predictable monthly meetings. Over 12-month period, at least 50% of staff should have opportunity to participate at least once. Identify up to 7 issues, but no more than 2 active plans per month (only one can be adopting, as they take longer). What should I be worried about?
Face—don’t tackle too many complicated issues too quickly, and don’t solve all the simple issues in the first 2 months either. Balance approximately one technical and one adaptive issue per month with specific tasks and timelines. Help with their Learning from Defects tool.

FAST FACTS

Adapted from:

www.dukepatientsafetycenter.com
Evidence: Over time results indicate that…

- Safety climate improves overall
- Perceptions of management improve overall
- Magic number for exposure of staff ≥ 60% having participated in at least one per year
- Nurse managers and charge nurses become more realistic (their safety climate scores actually decrease), while physicians, nurses, RTs, nurses aides, etc, improve.

2005 RCT of EWR at Memorial Hermann Hospital: 23 Clinical Areas

- Results for 23 Units Based on Assignment to Experimental/Control Group
  - Executives visited once a month / 3 months

- Baseline: 64.6%
- Post RTC: 56.5%

This RCT of EWR failed, but it assumed that staff were exposed to EWR, which they were not. This was our first evidence regarding exposure – that staff who were present during an executive visit improve.

When controlling for staff who were exposed to EWR, we found significant effects…

Safety Climate Scores across 21 Care Areas Exposed to EWRs

Bigger improvements in units with more room to improve…

Adapted from:
Frankel et al. HSR (2008)
Safety Climate Scores across Caregiver Roles Pre-Post EWR

- RNs improve over time, while Nurse Managers/Charge Nurses recalibrate.

% Reporting Positive Safety Climate

<table>
<thead>
<tr>
<th>Role</th>
<th>Baseline</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>Nurse Manager/Charge Nurse</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>Staff Physician</td>
<td>50</td>
<td>70</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>PCA/Hosp Aid/Care Partner</td>
<td>30</td>
<td>50</td>
</tr>
</tbody>
</table>

Adapted from: Frankel et al. HSR (2008)

Patient safety risk reduction

% of caregivers exposed to WR vs. % of caregivers reporting reduced PS risk due to WR

(r=0.831, p<0.001)
Improving Norms of Patient Safety: Safety Climate Items Responsive to Interventions

“The culture in this clinical area makes it easy to learn from the errors of others.”
“I am encouraged by my colleagues to report any patient safety concerns I may have.”
“I know the proper channels to direct questions regarding patient safety in this clinical area.”


Beware of Defensive Stress Coping Mechanisms for Managing Interpersonal Risk

Facing the risk of appearing:
- Ignorant
- Incompetent
- Intrusive
- Negative

You can solve this easily by:
- Not asking questions
- Not admitting mistakes
- Not inquiring into others’ work
- Not criticizing others’ actions or questioning organizational systems or processes


Beware of bright and shiny objects

- Work Avoidance:
  - Holding onto past assumptions, blaming authority, scape-goating, externalizing the enemy, denying the problem, jumping to conclusions, or finding a distracting issue that serves to restore temporary stability at the expense of lasting change
Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

Psychological safety

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A shared sense of psychological safety is a critical input to an effective learning system


Amy Edmondson
Best Practices: Humble Curiosity

- Help your staff to feel heard – unheard staff find an ear elsewhere, at your expense
- Remember your role as a leader isn’t always to solve problems, it is, at times to **listen** to staff and **learn** from them while you **empathize**
- Show curiosity in staff feedback –
  - Don’t be defensive: defensive leaders have defensive followers
    - if you are defensive: “Why was that so low...,” they will be defensive and not engage
    - instead engage “Teach me, what can be done to remove barriers so that your concerns are addressed?”

Psychological Safety Leadership Behaviors

It takes inclusive leaders who:
- Proactively invite input (Name/Role Activation)
- Are accessible (Present/Approachable/Therapist hat)
  - You can affirm feelings without affirming facts
- Acknowledge the limits of current knowledge
  - Change the goal for today from solving to understanding
- “Go first” (particularly in displays of fallibility)

*Inclusive leaders lower the psychological costs of voice and raise the psychological costs of silence*
Effective Executive Practices:

• Counteracting resistance and helping people to learn in psychologically safe way
• Listening/Empathy – help staff to feel heard, you can not always solve a problem, but to demonstrate that they taught you something is a valuable and often missed opportunity for leadership.
• Willingness to address the gap between the values that people hold, and the reality that they face
• Providing vision, and giving clarity and articulation to the goals of the unit/clinical area (reification)

Next Steps:

• Select a unit-based safety officer/safety champion
• Announce the onset of monthly executive visits
  – Ensure that staff from all disciplines and shifts are given advance notice of the visits (to come prepared with issues)
  – Using the 60% exposure target, determine the number of different caregivers that should attend each visit so that 60% of staff are exposed to the visit within 12 months.
• Select a few locations in which to conduct the partnership visits, use feedback from participants to determine the best location
• Determine the best venue for feeding back progress to participants – newsletter, email, bulletin board, etc.
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  - Humble Curiosity: “Help me understand how I can remove barriers”
- Classifies issues as technical vs. adaptive
- No more than 2 action plans generated per visit
- Accountability through timelines and appropriate pace

Reference List

- Pronovost et al. Jt Comm J Qual Patient Saf. 2004 Feb;3(2)
- Heifetz, Leadership Without Easy Answers. 2003 (book)
- Thomas et al. BMC Health Serv Res. 2005; Jun 8;5(1)
- Frankel et al. HSR (2008)