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
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 have generated better social, clinical, and operational outcomes.

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.”

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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.

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Interdependent Dimensions of High-Impact Leadership

New Mental Models
How leaders think about challenges and solutions

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

IHI High-Impact Leadership Framework
Where leaders need to focus efforts
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

IHI High Impact Leadership Framework

Create Vision and Build Will

Driven by Persons and Community

Develop Capability

Deliver Results

Shape Culture

Engage Across Boundaries

Patient safety creates new demands on leaders
Some keys for the new mental models

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

- Care is... personalised
- Care is... coordinated
- Care is... enabling
- Person is treated with... dignity, compassion, respect
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

The standard you walk past is the standard you accept

- If you are a member of staff and have a concern, then ACT
- If you are a member of public and have a concern, then TELL US by contacting our Patient Experience Team:
  Tel: 01935384706 Email: pals@ydh.nhs.uk Or scan:
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

Leadership creates

- Vision
  - A sensible and appealing picture of the future

- Strategies
  - A logic for how the vision can be achieved

Management creates

- Plans
  - Specific steps and timetables to implement the strategies

- Budgets
  - Plans converted into financial projections and goals
Characteristics of an effective vision

- Imaginable
- Desirable
- Feasible
- Focused
- Flexible
- Communicable
Over 7 years we have achieved:

- 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.

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

SSER February 2010: 0.35
55% Reduction SSER
111 days since last event

Average Days between events:
18 days (Rolling 12 month)
11 days (CY 08)
18 days (CY 07)
37 days (CY 06)

Medical Staff Leaders required mandatory Safety training for all 1700
All 11,000 employees trained as well
<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Event Type</th>
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<tbody>
<tr>
<td>Baby Girl V.</td>
<td>5/12/2008</td>
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<td>6/26/2008</td>
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<td>John B.</td>
<td>9/6/2008</td>
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<td>Shirley H.</td>
<td>12/23/2008</td>
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<tr>
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<td>6/18/2008</td>
<td>Med Error</td>
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<td>Teodur C.</td>
<td>1/29/2008, 2/12/2008</td>
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<td>8/5/2008</td>
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<td>Alvin G.</td>
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<td>Joseph R.</td>
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<td>Margarett H.</td>
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<td>Lance D.</td>
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<td>Miss L.</td>
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<td>Priscilla W.</td>
<td>8/30/2008</td>
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<tr>
<td>Harry S.</td>
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<td>Delay in Dx</td>
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<tr>
<td>Teodur C.</td>
<td>1/29/2008, 2/12/2008</td>
<td>Delay in Tx</td>
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<tr>
<td>Gary B.</td>
<td>6/13/2008</td>
<td>Fall</td>
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<td>Floralita H.</td>
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<td>Delay in Tx</td>
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<td>Mary C.</td>
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<td>Carla M.</td>
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<td>Med Error</td>
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<tr>
<td>Mary C.</td>
<td>12/19/2008</td>
<td>Fall</td>
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</tbody>
</table>

**A different look at our baseline**

![Image of medical setting with patient and healthcare provider]
Leading a 50% Reduction in events from baseline

- 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

- Edward R.
  4/23/09
  Wrong Side Procedure

- Dorothy R.
  1/28/09
  Delay In Treatment

- Monroe K.
  5/18/09
  Post Procedure Death

- Juanita A.
  5/14/09
  Delay In Treatment

- Willie B.
  11/5/09
  Med Error

- Johnny B.
  11/9/09
  Fall

- Jerry Y.
  11/7/09
  Fall

- Brenda R.
  10/14/09
  Delay In Treatment

- James H.
  10/25/09
  Post Procedure Death

- Lilliam C.
  4/3/09
  Retained foreign object

- Donna S.
  6/4/09
  Retained foreign object

- Scott G.
  9/5/09
  Delay in Treatment

- Pauline M.
  11/2/09
  Fall

- Rachel M.
  11/3/09
  Delay in Treatment

- Monro K.
  5/18/09
  Post Procedure Death

- Pauline M.
  11/2/09
  Fall
Every system is perfectly designed to achieve exactly the results it gets.
The simple, wrong answer

Blame somebody!
Answer #2 – Bad Apples

Frequency

Better ← Quality → Worse

The Problem
The Cycle of Fear

1. Increase Fear
2. Kill the Messenger
3. Filter the Information
4. Micromanage

The cycle continues with arrows connecting each step, indicating a loop or feedback mechanism.
Mid Staffs coding of palliative care vs HSMR

Graph showing the percentage of deaths coded as palliative care in England over the years from 2004 to 2011. The percentage increased significantly from 2008 onwards.
Another way?

Old Way
(Quality Assurance)

New Way
(Quality Improvement)

Requirement, Specification or Target

Reject defectives

No action taken here

Action taken on all occurrences

Better  Quality  Worse

Better  Quality  Worse

Source: Robert Lloyd, Ph.D.
Openness and honesty when things go wrong: the professional duty of candour

The professional duty of candour

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 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 and The Code: Professional standards of practice and behaviour for nurses and midwives. 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 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

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Level</th>
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<tbody>
<tr>
<td>10. Unitive</td>
<td>Post-Post-Conventional</td>
</tr>
<tr>
<td>9. Magician</td>
<td>Post-Conventional</td>
</tr>
<tr>
<td>8. Integrator</td>
<td>Post-Conventional</td>
</tr>
<tr>
<td>7. Individualist</td>
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<tr>
<td>6. Achiever</td>
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<tr>
<td>5. Expert</td>
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<td>4. Conformist</td>
<td>Conventional</td>
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<tr>
<td>3. Self-serving</td>
<td>Pre-Conventional</td>
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<td>2. Impulsive</td>
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<td>1. Undifferentiated</td>
<td>Pre-Conventional</td>
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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
Status, rank, and role boundaries as inhibitors
Is deferential behavior always safe?
What leadership behaviors will keep you informed?
High-Impact Leadership Behaviors: What leaders do to make a difference

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