2010 DUHS Patient Safety Center Courses Offered

www.dukepatientsafetycenter.com

- Patient Safety Officer Training
- Physician Leadership in Patient Safety and Quality
- Executive Leadership in Patient Safety and Quality: Executive Safety Partnerships
- Safety as a System: Finding, Fixing, and Learning from Defects
- TeamSTEPPS Short Course: Brief Introduction for Managers
- TeamSTEPPS Implementation: Train the Trainer
- Conflict Resolution and Coaching for Managers, Preceptors, and Frontline Staff
- Enhancing Caregiver Resilience: Burnout Overview / Intervention
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
Leadership is…

Getting groups of people to do things that make the world a better place
Quality is...

nebulous, lonely, & exhausting
Successful Executive 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 Partnerships

• Monthly
• Use of unit based safety officer
• Trained executive/safety officer
• Targets 60% of staff participating at least once
• 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
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.
  - Pronovost et al. Jt Comm J Qual Patient Saf. 2004 Feb;3(2)
Executive Partnerships

Clinical Area

Unit Based Safety Officer

Executive

Hospital Quality Council/Patient Safety Committee
Executive Partnerships

Clinical Area

Unit Based Safety Officer

Linked Executive

Hospital Quality Council/Patient Safety Committee
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
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
Best Practices: Empowerment

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
  - 20 Minute online course
- Learning From Defects
- Culture Debriefing / Checkup Tool
Practical Tools to Improve Patient Safety: Reframe away from Blame

Seeing Safety as a System
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:
Learning from Defects

- What happened (Brief defect description)?
- Why did it happen (what factors contributed +&-): System factors, e.g.: staffing, workload, equipment, production pressure, other departments, caregiver factors (training/fatigue/attitude), management support, physical environment (space/noise), failure of policy/procedure, patient condition (complexity/language)
- What can we do to reduce the risk of it recurring with different caregivers?
- How will we know the risk was reduced?
- With whom should we share our learning?

Learning from Defects Fast Facts

What do I need to know?
Purpose of learning from defects in a structured way is to help this clinical area “learn how” to operationalize best practices so that they solve problems while building capacity to improve quality in the future.

What do I need to do?
Use brief (30-60min) defect learning discussions to explore & resolve system factors involved in the defect. Focus discussion on specific actions to reduce the likelihood of defect recurrence.

What should I be worried about?
Protected time to discuss monthly or in response to an event in the unit, meet in a safe place for open discussion, try to keep group size to 5 or fewers if possible.

ADAPTED FROM:
Safety Culture Debriefing & Action Tool

- What item/issue is most relevant to the group due to recent events or activities? Item/Score/Why
- Share examples of how this item/score reflects your experience in this unit.
- Envision the ideal unit where 100% agree strongly with item. Provide specific behaviors or processes that are typical, policies or procedures that are written or enforced, everyday norms.
- Agree on one actionable step toward the ideal unit. Agree on a task, nominate a person responsible, a follow-up date, and the external leader or committee to whom this plan is disclosed.

Safety Culture Debriefing & Action Fast Facts

What do I need to know?
Purpose of debriefing in a structured way is to produce a specific data-driven next steps to improve the local environment in this unit. These are specifically bottom-up: using grassed roots interest to surface and drive sustainable improvement in areas of concern to frontline workers rather than leadership. Nominated individuals for action steps are often safety champions deserving of more training, responsibilities, or titles such as patient safety liaison, unit safety champion, or unit-based safety officer.

What do I need to do?
Use the debriefing tool to conduct a brief (40-90min) structured discussion based on data, with approximately 10 minutes per bullet. Roughly 5-7 volunteer participants for every 20 people in the unit (e.g., a unit with 40 people would conduct two separate debriefings). If there are many disciplines represented, or subgroups, consider debriefing them separately first, then offer interdisciplinary or inter-generational follow-up debriefings using the nominated individuals from the initial debriefing. Compare the action steps identified by the different debriefings to identify patterns or additional opportunities.

What should I be worried about?
Psychological safety of participants is critical, so providing protected time without management present empowers small group dynamics to thrive. Help managers understand that these grassroots debriefings are to build capacity among staff without adding significant burden to management—think of them as means to promote shared ownership for quality among staff. Managers can expect to review the debriefing output and offer to help with action steps.

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
Executive Partnerships II: Evidence Based Practices
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…
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?”
PSO Toolbox

Data Driven Triage of Improvement Tools

- Staffing levels inadequate?/info lost at shift change?: consider **Morning/Shift Briefings**
- Interdisciplinary patient management issues?: consider **Daily Goals**
- Trouble resolving conflicts/lack of role clarity?: consider **Shadowing Exercise**
- Difficulty speaking up?: consider standardizing through **SBAR** or using **Critical Language**

**If** staff lack consensus about quality and safety issues?
  - Share “Safety as a System” module with staff: [www.dukehealth.org/quality](http://www.dukehealth.org/quality)

- Feel unsafe or unengaged in safety and quality?
  - **Learning from Defects**
  - **Executive Partnership**
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:
“How will the next pt in this clinical area be harmed?”
“Was a pt recently harmed because of less-than-safe care?”
“What can this unit do on a regular basis to improve safety?”

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 by staff, 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 60% of staff should have opportunity to participate at least once. Identify up to 7 issues, but no more than 2 action plans per month (only one can be adaptive, as they take longer).

What should I be worried about?
Pace—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.
Evidence: Over time results indicate that...

- Safety climate improves overall
- Perceptions of management improve overall
- Magic number for exposure of staff $\geq 60\%$ 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

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.

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

Results for 23 Units Based on Assignment AND Exposure to at least one visit from the Executive

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

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.

Adapted from: Frankel et al. HSR (2008)
Psychological safety

Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

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

Amy Edmondson
SURVIVAL

WHEN YOU ARE IN DEEP TROUBLE, SAY NOTHING, AND TRY TO LOOK LIKE YOU KNOW WHAT YOU ARE DOING
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

Framing the Feedback
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)
Cheat Sheet: Know Where to Publish

- Some problems are best solved as a research project
- Use the Journal Primer to encourage staff to help others beyond their clinical area through the literature
Primer: Quality & Safety Journals

• **General Medical Journals that publish quality and safety manuscripts** (good science and well written)
  - NEJM
  - JAMA
  - BMJ
  - Annals of Internal Medicine
  - Lancet

• **Policy and Health Services Research Journals**
  - Health Affairs (top policy journal)
  - Medical Care (robust methods health services research journal)
  - Health Services Research
  - Biomed Central Health Services Research

• **Quality and Safety Journals**
  - The Joint Commission Journal on Quality and Patient Safety (science is less rigorous, but very good for local quality improvement projects that do not have robust data)
  - Quality and Safety in Healthcare (offshoot of BMJ)
  - The American Journal of Medical Quality
  - The Journal of Patient Safety
  - The International Journal of Quality Healthcare
  - Implementation Science (new journal in biomed central)
  - The Patient (new journal on patient experience)

• **Specialty Journals** (most will publish quality and safety papers)
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.
Executive Partnerships

• Monthly
• Use of unit based safety officer
• Trained executive/safety officer
• Targets 60% of staff participating at least once
• Objective is psychological safety & empowerment of staff
  • 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

– Thomas et al. BMC Health Serv Res. 2005; Jun 8;5(1)
– Frankel et al. HSR (2008)