Local Leaders: Keys to the Learning System Puzzle!

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Disclosures

- Nancy Iversen and Christine Sammer have no relevant financial or relevant nonfinancial relationships to disclose.
- Terri Christensen Frankel disclosure: Chief Operating Officer of Safe & Reliable Healthcare, a cultural assessment, design & consulting firm that produces LENS.
Session Objectives

- Learn how to accelerate the development of culturally healthy learning systems in your organization.
- Learn how to engage and enable frontline leaders with tools to support the development of learning environments.
- Explore the personal, social and structural factors that enable organizations to create highly reliable learning environments.
Framework for Safe, Reliable & Effective Care: The Learning System Puzzle

Published Feb 2017 with the Institute for Healthcare Improvement [IHI]
Framework for Safe, Reliable & Effective Care

- **Leadership**
  - Leaders are Guardians of learning, respect, and psychological safety.

- **Culture**
  - Leaders and Teams, Psychological Safety, with clarified Accountabilities. Collaborative Negotiation to navigate the differences.

- **Learning System**
  - Defects and Ideas, Measured and Improved in pursuit of Reliability. The process always Transparent.

**Keys to The Learning System Puzzle**

The Framework for Safe, Reliable & Effective Care developed by IHI and Safe & Reliable Healthcare.
Each healthcare system and hospital is comprised of work-settings that are linked together.

Each work-setting’s capacity is determined by the strength of its framework components.
We have a tool, a Framework for Safe, Reliable and Effective Care

Structured way of thinking about all the things organizations should do

Some are common sense, some you may already be doing

If these considerations/behaviors are common sense AND so vital then......
Why isn’t everyone doing them?

Can we provide evidence that doing these things will drive outcomes?

Are there different ways of doing them that work better than others?
70% of Healthcare Improvement Fails Because Cultures Don't Support Improvement

Total 8 year change in SAQ and AHRQ US Benchmark
[Westat, Pascal]
In US:
Ongoing Safety, Culture & Burnout Issues

- 54% of physicians are Burned Out
- 47% of staff unable to speak up to share ideas or concerns about patient care
- 33% of patients suffer from an AE; 3rd cause of death


S&R SCORE Database

A wide variety of skill among local leaders

10%
- Absent
- Burned Out
- Socially Inept
- Disinterested

80%
- Clinically excellent
- Well meaning
- Socially Adept
- Inadequately Trained

10%
- Engaged
- Knowledgeable in
  - Organizational development
  - Whole system change
  - Measurement to manage
  - Relentlessly focused on process
  - Know culture IS a process
Cultural health determines the ability to improve clinical processes, quality and outcomes.

BSI = Blood Stream Infection from Central Lines

NEJM 2004 Pronovost, Sexton
Published Impact on Culture Scores: Giving Voice and Closing the Loop

Michigan SCORE Data, with and without Closing the Loop

- Giving Voice: 23% Higher SCORE Measures when WalkRounds feedback given
- n=16,797

Listen.
Close Loop.
Repeat.
Goal:

DRIVE OUTCOMES BY FOCUSING ON CULTURE AND INFLUENCING BEHAVIOR

Assumptions

Structured Framework

Culture is directly related to outcomes & ability to improve

Culture is a set of behaviors that can be influenced
Tools alone do not drive change

Influencer, The New Science of Leading Change; Grenny, et al

Once we have a clear goal (we do) and a set of behaviors (we do, in the Framework)

Then we need to look at the ability (can I?) and motivation (why should I?) of

- Individuals
- Teams
- Organizational Structure
Influencer
The New Science of Leading Change

MOTIVATION

ABILITY

PERSONAL

Help Them Love What They Hate

Help Them Do What They Can’t

SOCIAL

Provide Encouragement

Provide Assistance

STRUCTURAL

Change Their Economy

Change Their Space
Driving Outcomes Through Changes in Behavior

● FOCUS on a few key behaviors
  ○ Giving voice and managing issues
  ○ Huddles
  ○ Acting on defect data
  ○ Managing improvement

● What are successful leadership strategies?
  ○ Personal
  ○ Social
  ○ Structural
Framework for Safe, Reliable, and Effective Care

Guardians of Learning, Psychological Safety, Respect

Keys to The Learning System Puzzle
Ask questions.
Ask for feedback.
Be respect fully critical.
Make innovative suggestions.

“I’m accountable for my actions but won’t be held accountable for current system flaws”.

Keys to The Learning System Puzzle
MOTIVATION

Help Them Love What They Hate

ABILITY

Help Them Do What They Can’t

PERSONAL

Provide Encouragement

SOCIAL

Provide Assistance

STRUCTURAL

Change Their Economy

Change Their Space
Psychological Safety

Four attributes:

Anyone can ask questions without looking stupid.

Anyone can ask for feedback without looking incompetent.

Anyone can be respectfully critical without appearing negative.

Anyone can suggest innovative ideas without being perceived as disruptive.
Psychological Safety

Why are people afraid to “speak up”?

People choose their behaviors based on what they think will happen to them as a result.

The Great Persuader is Personal Experience
Personal Ability:
Engage People in Practicing New Behaviors
Social Motivation:
Create New Norms & Make the Undiscussable Discussable
A just culture refers to “appropriate accountability.” In the aftermath of an adverse event, when things go awry or when people make mistakes, the individual and the teams are assured that leaders will evaluate accountability justly, taking into account what is known about complex systems, human factors, and human fallibility.\footnote{Frankel & Leonard}
Accountability--A Just Culture

Supports system learning through error reporting without fear of retribution for mistakes.

A clear line must be drawn between acceptable and unacceptable behavior.
Framework for Safe, Reliable, and Effective Care

Guardians of Learning
Psychological Safety
Respect

Keys to The Learning System Puzzle

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At all levels, make culture and operations visible, using measurement, survey etc.

Improving work processes and patient outcomes using standard improvement tools including measurements over time.

Regularly collect and learn from defects and successes.

**Keys to The Learning System Puzzle**
At all levels, make culture and operations visible, using measurement, survey, etc.
Transparency “Shining the Light”

Is the free, uninhibited flow of information that is open to the scrutiny of others

Essential element that enables operational & culture change to occur

Promotes accountability, catalyzes improvements in quality, safety, and ethical behavior
Safer Care Through Transparency

### Patient Safety in Action
“Not on our Watch”

A publication from the Patient Safety Committee

Summer 2010
Volume 1 Issue 2

**Did you know? Billings Clinic has had wrong site / wrong patient procedures?**

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<th>Type</th>
<th>Location</th>
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<td>4. OR</td>
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<td>5. Excision of skin lesion</td>
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**Personalizing Safety**

**John’s Story**

John, an 80-year-old patient, was admitted for a pacemaker implantation due to syncopal episodes. John has a history of right-sided hemiplegia as a result of a head injury in his teen years. Due to his right-sided hemiplegia, John made a special request to have his pacemaker generator placed on his right side (normally, pacemaker generator is placed on the left side for a right-handed person). Despite this request, the pacemaker generator was not placed correctly, leading to a near miss event.

**Shirley’s Story**

Shirley, a 73-year-old patient, received a right femoral nerve block following her left total hip arthroplasty. During Shirley’s admission to the PACU, the handoff between the OR nurse and the PACU nurse was interrupted. The PACU nurse assigned to Shirley had to leave PACU to transfer a patient to the floor. In the process, Shirley’s postoperative pain management was compromised, resulting in a near miss event.
Frameworks for Safe, Reliable, and Effective Care

Keys to The Learning System Puzzle

Improving work processes and patient outcomes, using standard improvement tools including measurements over time.

Regularly collect and learn from defects and successes.

© IHI and Safe & Reliable Healthcare
Learning boards capture ideas and issues from everyone

ANALOG: proven results
DIGITAL: available everywhere on any device.
Influencer
The New Science of Leading Change

**Motivation**
- Help Them Love What They Hate

**Ability**
- Help Them Do What They Can’t

**Personal**
- Provide Encouragement

**Social**
- Provide Assistance

**Structural**
- Change Their Economy
- Change Their Space
**Clinical Aim**

- Phased approach: ED to IPM (July-Oct)
- DA to IPM (Nov-Feb)
- ICU to IPM (Mar-Jun)

**Strategy**

- Data review of FTRs for common patterns.
- Who/How determined to be deemed FTR? Define FTR.
- FTR review per manager and providers.
- Clear chain of command re: tx to higher level of care. (Names and Numbers)
- Continue FTR review per IPM Safety Team / Manager.
- FTR Review per Manager and Providers
- Clear chain of command re: tx to higher level of care. (Names and Numbers)

**Tactics**

- Clear chain of command re: tx to higher level of care. (Create with IMR, Hospitalist & FPR)
- Create Communication Brochure for Physician Groups (IMR & Hospitalist)

**Tests**

- Test – 6 hours. Is patient transferred within 6 hours of admission to a higher level of care the correct time frame?
- Determined 6 hours was not long enough. Team chose to use 12 hours.
- Test run for DAs drive by assessment?
- Debriefings
- Trial Handoff Tools
- Run Chart Trends

**Correct Bed for the Right Patient the First Time**

*Measure: Measured by a 90% Success Rate by June 2016*

**Communication for Support**

- Develop Appropriate Screening Tool for DA
- Improve Handoffs for Admits to IPM
- Develop an Effective Handoff Tool
- Collaborate with ICU/Pam Z, CAT Team and MEWS Scores
- Collaborate with ED
- Involve Transfer Center for DAs

**Tests**

- Communication process tool created.
- Shared with all teams.
- Created thumbs up/down staff eval.
Failure of Appropriate Patient Placement

IPM Direct & ED Admits

January 2015 - March 2016

Downward trend indicates improvement.

1. ED/IPM Bedside Handoff March 2016
2. IPM Direct Admit Ambulance April 2016
Essential Partners

Karri Vesey, RN & Peter Light, MD

“I am surprised by how well it has gone. Not one person at a recent staff meeting had any glowing issues. It is almost like this is the standard now.” – Karri Vesey

“I have found the ED/IPM BSR project to be extremely exciting, to have multiple care giver teams with physician support joining together and streamlining care for medical inpatients in order to provide the best service and care.” – Peter Light
Our Year In A Word

- Commitment
- Perseverance
- Hope
- Solutions
- Impact
- Unity
- Change
- Awareness
- Safety
- Rewarding
- Difficult
- Powerful
- Communication
- Teamwork
- Accountability
- Believe
Structural Ability: Change Their Space
Make the Invisible Visible
Structural Ability: Change Their Space
Make the Invisible Visible
Driving Outcomes Through Changes in Behavior

- **FOCUS** on a few key behaviors
  - Giving voice and managing issues
  - Huddles
  - Acting on defect data
  - Managing improvement

- What are successful leadership strategies?
  - **Personal**
  - **Social**
  - **Structural**
Morning Huddle on Inpatient Medical Unit

Billings Clinic Inpatient Medical Huddle
Driving Outcomes Through Changes in Behavior

- What key behaviors did you observe?

- What successful leadership strategies did you observe?
At the core of every true talent there is an awareness of the difficulties inherent in any achievement, and the confidence that by persistence and patience, something worthwhile will be realized.

Eric Hoffer
American Moral & Social Philosopher
Questions?