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The Practice of R-E-S-P-E-C-T...
find out what it means to you

December 10, 2018
IHI National Forum
Orlando, Florida

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Institute for Healthcare Improvement (IHI)
Disclosures

Dr. Sokol-Hessner is Faculty at the Institute for Healthcare Improvement for the Conversation Ready initiative that aims to improve the reliability of advance care planning for seriously ill patients
Learning Goals

• Recognize the central role that leadership engagement plays in successful implementation and strategies for achieving a culture that promotes dignity and respect
• Practice using a novel framework for assessing, categorizing, prioritizing, and learning from non-physical harms from disrespect
• Discuss the role of Patient and Family Advisors in building a culture of respect
• Analyze institutional readiness for assessing harms from disrespect
Introductions

- Pat Folcarelli
- Lauge Sokol-Hessner
- Tobie Atlas
- Barbara Sarnoff Lee
- Frank Federico

- What are your roles?
- A brief note about confidentiality
Raise your hand if...

• You had a chance to do the pre-work? *(it’s really ok if you didn’t!)*
• Your patient safety, risk management, and patient relations departments are integrated?
• You apply a “just culture” algorithm after harm events?
• You have Patient Family Advisors working within your organization?
• You have a department or committee that focuses on the patient experience?
  – What is its relationship to the quality/safety committee structure?
• Do you feel that others in your organization recognize or understand the importance of the patient/family experience?
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30-12:45p (15min)</td>
<td>Introductions and Welcome</td>
<td>All presenters</td>
</tr>
</tbody>
</table>
| 12:45-1:05p (20min) | Disrespect in Healthcare  
  Breakout: What’s your experience? | All presenters                   |
| 1:05-1:15p (10min) | BIDMC Approach to Preventable Harm                                   | Sokol-Hessner, Folcarelli        |
| 1:15-2:00p (45min) | Tackling Non-Physical Harm: RCA² approach  
  Breakout: Describing  
  Breakout: Prioritizing | Sokol-Hessner, Folcarelli        |
| 2:00-2:15p (15min) | Break                                                                | --                               |
| 2:15-2:30p (15min) | Reflections on Assessing Cases and Pivoting Prospectively            | All presenters                   |
| 2:30-3:30p (1hr)  | Engaging Patients and Families in Preventing Future Harm             | Atlas, Sarnoff Lee               |
| 3:30-4:00p (30min) | Leaving in Action                                                    | Federico                         |
Case 1 *(this was the pre-work case)*

A patient and her sister come to an appointment with an oncologist. The patient is greeted in the clinic and placed in the room by a medical assistant. 35 minutes later the patient’s sister comes out to ask about the delay in being seen. It is then discovered that her oncologist is not in the clinic that day. When the sister asks how this could happen, a staff member responds by saying “It’s not my job to schedule appointments.” The patient takes her care to another hospital.
Case 2

An 85 year old man who is an inpatient in the hospital with pneumonia suffers a fall in the early evening. The team caring for him obtains x-rays and discovers he has fractured his hip. No one calls the family to let them know about the fall. The first notification to the surrogate decision maker (son) to let him know about the fall is from the orthopedic surgeon calling to get operative consent for repair of the broken hip. There had been no notification to the family about the fall or the subsequent x-rays. The family is very upset.
Case 3

A patient posts this on the hospital’s Facebook page. “Ok...I have surgery scheduled today and the paperwork says check in @ 5 am. I wake at 3:30 to make the 1 hr. drive from Cape Cod only to learn that one can never check in B4 6 am?? The staff here states it is a little trick they do?? Hope surgery doesn’t have any little tricks or surprises!” Upon investigation it’s discovered that the surgeon’s office staff has been telling patients to get there early as the traffic in Boston is terrible and a lot of patients scheduled for the first case of the day arrive late.
Case 4

A patient had a procedure that required her to stay overnight. She was in a two-person room. Her doctor came in to talk with her about how the procedure went and mentioned the fact that she had HIV in his description of her condition. While the patient already knew this, the doctor spoke loud enough for the roommate to hear. The roommate yelled, “I am not going to share my room with an AIDS patient!” The patient felt her privacy was violated, and was very upset.
Case 5

A patient dies unexpectedly at BIDMC and the BID-network PCP is not notified. A week later, the PCP learns of the patient’s death from his bereaved wife when she calls the PCP’s office with questions. The PCP has cared for the patient’s family for many years so knows them very well. The patient’s family has been grieving deeply and the PCP would have wanted to support them during that time. The PCP notes this is not the first time this has occurred; she is quickly able to name two other patients who received primary care in her clinic and died in the hospital but the primary care physicians were not notified.
Case 6

An inpatient being taken in for a procedure is asked to remove his wedding ring, which is a family heirloom that belonged to his now deceased father. A staff member takes the ring and says he will “lock it up.” When the patient awakens from his procedure no one remembers who took the ring, and can not be found. The heirloom is lost and never recovered.
Reflections

• Let’s switch to Mentimeter for a moment...
• Thoughts from a patient-family advisor
Elements of Respect

- Listen to Understand
- Transparency
- Inclusion
- Psychological Safety
Reflections

• If you were the patient in the first case (35 min wait in a clinic exam room for a doctor who wasn’t even there that day), how would you respond?

• If that case – or one like it – happened at your health care organization, how would your organization respond?
Taking a new perspective

NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute. (2017). Americans’ Experiences with Medical Errors and Views on Patient Safety. CHICAGO, IL – web/phone-based survey of >2500 Americans
Table breakout: Types of disrespect

Take 5 minutes to discuss:
Where do you see disrespect to patients in your organization?
How do you hear about those events, and who handles them?

Then pick someone to report back from your table
Relationship between disrespect & non-physical harm

Disrespect

Many different professional and organizational behaviors can be perceived as disrespect

Consequences

Non-physical harm
Emotional
Psychological
Socio-behavioral
Financial

Physical harm
Diagnostic error (Giardina et al. 2018)
Treatment-related problems
Taking a new perspective

• When asked about harm, patients emphasize the non-physical
  – Evidence suggests they may be equally as prevalent as physical harms
• Some patients seem to be at higher risk of non-physical harm
• Such harms can persist long after the inciting events
• Impacts extend beyond patients
  – Families
  – Health care professionals
  – Health care organizations
• Such harm can be treated with the same rigor we apply to physical harm
  – Utilize existing institutional resources and processes

Massó Guijarro et al. 2010; Kuzel et al. 2004; Entwistle 2008; NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute 2017; Ottosen et al. 2018; Sokol-Hessner, Folcarelli & Sands, BMJ Qual Saf 2015; Sokol-Hessner et al. 2018
Considering the history of preventable physical harm e.g. CLABSIs

“Harm just happens sometimes”  
*Status quo*

“Harm doesn’t always have to happen”  
*Innovation*

“Let’s aim for zero!”  
*New expectations and aspirational goals*

“It’s really happening quite a lot, and the consequences are severe”  
*Recognizing the scope*

“Here, use these interventions to prevent harm”  
*Spread*

*Supported by systems for identifying, capturing, analyzing, and discussing harm events*
Experience with physical harm

~7000 incidents reported each year
Preventable harm at BIDMC

In 2007 we stated a goal:

“eliminate preventable harm by January 1, 2012”

Preventable: standard of care was not met, or there are reasonable improvements that would decrease the likelihood of a similar future event

Spoiler alert...

...we didn’t get to zero!
Experience with physical harm

Severe and “preventable”

# of incidents per year

~7000

~150

43
Why report individual events instead of rates?

Both are useful and important

Stories about actual events are more engaging
• Tangible and aspirational

Rates require a numerator and a denominator
• The numerator is the count of individual events
• The denominator is anyone who was at risk – often hard to determine
Pause

Questions? Reflections?
Experience with non-physical harm

Patient Relations

“Noise”
~3,400 incidents reported each year
Tackling non-physical harm

Foundations

• “Eliminating Preventable Harm”
• Keeping Patient Safety & Patient Relations together
• Transparency and Just Culture
• Patient-Family Engagement
• Communication, Apology, and Resolution
• Peer Support and Workplace Violence Mitigation
  – Joy in Work: http://www.ihi.org/Topics/Joy-In-Work
Working group

- Patient Safety
- Health Care Quality
- Nursing
- Hospital Medicine
- Social Work
- Palliative Care
- Ethics Support Services
- Interpreter Services
- Communications
- Volunteer Services
- Community Benefits
- Patient Care Assessment Committee (Board/Governance Committee)
- Performance Assessment and Regulatory Compliance
- Patient-Family Advisors

Definitions

Dignity
Each person’s intrinsic, unconditional value as a human

Respect
The actions that honor and acknowledge dignity
Learning about events

Calls/emails/letters to Patient Relations

Adverse event reports from staff
- Same system for physical harm
- Witnessed or second-hand

Reviewing events

Interdisciplinary group
- Director of Patient Safety
- Patient Safety Coordinator
- Patient Relations specialist
- Patient Safety Project Manager

Initially independent, then all together
- Describe, categorize, prioritize
Incident analysis for non-physical harm
Using an RCA²-like approach

- Negative experiences in health care
  - Reduced risk of future negative experiences
  - Breakout: Your organization’s current state

  Patient-family engagement plays a role throughout

  Some events are reported
  - Breakout: Brainstorming improvements

  Non-physical harm event reports
  - Breakout: Describing
  - Breakout: Prioritizing

  High-risk events

  Focused efforts to prevent future disrespect
  - Sharing findings with operational leaders

  Breakout: Prioritizing

  Breakout: Describing

  Breakout: Brainstorming improvements
Describing

<table>
<thead>
<tr>
<th>Key elements</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Processes</td>
<td>Groups of related actions taken to fulfill patient-family care needs. Using them helps aggregate learning and connect it to the group(s) responsible for improvement.</td>
</tr>
<tr>
<td>Contributing factors</td>
<td>These “set the stage” for disrespect. “Every system is perfectly designed to achieve the observed outcomes”; we must change the system if we want to achieve different outcomes.</td>
</tr>
<tr>
<td>Professional &amp; organizational behaviors</td>
<td>Naming perceived disrespectful behaviors helps convey the patient-family experience (which may be different from the intent of the professionals/organization). Must pair with Just Culture.</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Once disrespect has occurred, these lessen or worsen the consequences. Can be intrinsic or extrinsic to the patient.</td>
</tr>
<tr>
<td>Consequences</td>
<td>These can help others – especially organizational leaders – appreciate a “reason for action” and feel a “sense of urgency.”</td>
</tr>
</tbody>
</table>
Table breakout: Describing

Take a few minutes to review the cases and fill in the behavior(s) you can imagine the patient/family might have experienced

Then discuss as a group
Prioritizing

Two reasons we need to do this

• Too much to fix, too few resources
  – Too many potential cases, can’t look at all of them in-depth
  – Focus our limited resources by limiting the number of cases
• Challenging to generate consensus about the need for action
  – Lack of consensus $\rightarrow$ limited cooperation $\rightarrow$ limited/no improvement
  – Transparent, formal, risk-based process more likely to lead to consensus
Prioritizing

• Severity
  – Patient-family perspective
  – Organizational perspective

• Frequency

• Alignment with other initiatives
Table breakout: Prioritizing

Take a few minutes to individually:

1. Consider the patient-family perspective
   
   *Try to put yourselves in the shoes of the patient-family. Does this seem to be mild, moderate or severe?*

2. Consider organizational perspective
   
   *How often does this happen, and if it recurred, how often do we think there would be serious consequences? Does this seem to represent mild, moderate, or severe risk of future harm?*

Then discuss your ratings as a group
Reflections on Assessing Cases

What was that like?

Often limited information about what exactly transpired
- “He said...” and “She said...”
- Especially lacking non-verbal communication

Perceived as “soft”

Both individual and system factors contribute

Important conversations about risk and next steps
Take a 15 minute break!
Experience with non-physical harm

# of incidents per year

~3300 364 70

After describing, categorizing, prioritizing...

Looking backwards helps us...

- **Understand what happened**
  - Peer review and cause mapping

- **Promote accountability**
  - Individual behavior
    - Apply Just Culture
      - Human error (slips)
      - At-risk behavior (taking shortcuts, drifting from standards)
      - Reckless behavior (ignoring accepted standards)
    - Leaders’ design of systems of care

- **Learn how to prevent future harm**
Pivoting prospectively to prevent harm

Cases are discussed at a series of meetings...

• Departmental Quality Improvement (QI) Directors
• Board-level Quality and Safety Committee
• “Action Meeting”
  – 1 hour, monthly
  – Quality/Safety and Operational leaders, and soon a Patient/Family Advisor
  – De-identified, brief but comprehensive analyses of all high-risk cases since the last meeting
  – Ask ourselves:
    • What themes are we seeing month-to-month?
    • Is there an existing related initiative that will help prevent similar future events, or do we need a new one?
Care processes

• Ambulatory care access
• Hospital bed management
• Encounter initiation
• History and physical exam
• Discussions with patients about diagnosis, prognosis, treatment options, consent, or shared decision-making
• Medical record documentation
• Treatment
• Assistance with inpatient ADLs
• Family engagement and support
• Personal possession management
• Privacy
• Adverse-event management
• Hospital discharge
• Post-death care
An under-recognized care process: Care after death

Discharge Disposition
Death Pronouncement and Causes of Death
Medical Examiner
Asking about an Autopsy
New England Donor Services (NEDS)
Formerly New England Organ Bank (NEOB)
Notifications
Finalize Report of Death

About Grieving

Grief is the process of adjusting to loss. Most of us will experience one’s death at some point in our lives. While grief can be painful, it is important to know that grief is a normal response to loss, and that it is important to allow yourself to feel what you feel.

What to Expect in the First Few Weeks

Soon after the loss of a loved one, many people experience some physical and emotional changes. These feelings last, or how intense they are, is not the same for everyone and depend on many factors. There are many good days and bad days, peaceful moments and tough times. It is important to remember that this is a normal and normal process and that everyone reacts differently.

Common Physical Reactions
- crying or sobbing
- changes in sleep patterns
- numbness
- headaches

Common Emotions
- confusion
- shock
- anger
- despair

Dear Family of [deceased patient’s name],

We are writing at this time to let you know that the autopsy results for [patient name] are now available.
Table breakout: Brainstorming improvements

Take a few minutes to individually consider what improvements could be made to prevent these cases from happening again – be sure to look at the contributing factors for each case

Then discuss your ideas as a group
They’re on Our Team

Patients and Families as Partners in Quality and Safety
Patient-family engagement

- What is patient-family engagement?
- What are ways to engage patients and families?
- What are the benefits?
Definitions

• **Patient Activation**: knowledge, skills, confidence a person has in managing their own health care

• **Patient Engagement**: partnership between patients, families and staff to improve the quality, safety and experience of care

• **Patient/Family Centered Care**: respectful and dignified care that honors patients needs, values and preferences
Breakout: Patient/Family Engagement

Think about patient engagement in your organization. Discuss...

- Successes and how you got there
- Fears and concerns
- Challenges and barriers
Address on envelope: “Karen (Prefers to be called Mal) Malme”

Got the results of my mammogram (all good) and this is what was mailed to me

Date: OCT 23, 2018

Dear Ms. KAREN (PREFERS TO BE CALLED MAL) MALME

Thank you for choosing the Beth Israel Deaconess Medical Center for breast care. The mammogram you had on OCT 22, 2018 shows no eviden
Partnering with Patient/Family Advisors on Respect and Dignity
Advisor Rounding

Privacy

• “Came in through ER and was put on a stretcher for the next 10 hours. The lack of privacy was not a comfortable situation as she has a tracheotomy and clearing it was embarrassing.”

• “PT was sitting on the bed in front of the window and asked to have diaper change done in the bathroom. Aide said it was too crowded in there. Pt. felt that aide was not sensitive to her sense of decency and privacy. Eventually patient was able to get the blinds pulled down.”
Partnering with Patient/Family Advisors on Respect and Dignity
Advisor Rounding

Environment of Care
• Upon arrival, the toilet was dirty and the bathroom smelled of urine. Roommate's floor littered with band-aids and other detritus and no one came to clean all day.

Responsiveness and Communication
• After 45 minutes of waiting for breakfast he asked his nurse if it was on it's way. Patient felt nurse was rude to him by saying he would have to wait because it's "not a hotel".
• Staff have a conversation in front of her and call her 'she'. As if she is not there. She spoke up and said "my name is xxx".

Personal Belongings
• “The Pt said the night that he was admitted, one of the nurses was going through his pants pockets, and when he questioned her, she did not answer him and left.”
Mining for Gold
Where we started...
How we welcomed families:
Framing the question ...

- What are we trying to accomplish?
- How will we know a change is an improvement?
- What changes can we make that will result in improvement?

How can we get better?

ICU Patient/Family Advisory Council
Creating the Adult ICU Advisory Council

**Candidate Identification**
- Exit surveys
- Staff referrals
- Posters/brochures

**Screening process**
- Survey review
- Discussion with staff
- Personal interviews in collaboration with Social Work

**ICU Advisory Council**
ICU PFAC
(Intensive Care Patient and Family Advisory Council)

• Patient/family advisors and staff members
• Members set goals
• Meetings at regular intervals (bimonthly)
• Evening meetings/meal/parking reimbursement provided
• Expectation of one year of service
Themes from the First Meeting

Communication

• How can I get the information I want & need, when I need it?
• Who can I trust to give me the “true” information?

Partnership in caring

• Visiting hours
• Too many rules
• How to personalize the care

★ Environment: Cold, dull, uncomfortable, boring
Project: Waiting Room Revitalization

• Project launched
• Funding acquired
• Designer engaged

• ICU PFAC reviews plans and sends designer back to drawing board
With PFAC partnership, the waiting room went from this...
To this....
Family Sleep Room

ICU Family Sleep Room

To find out if this room is available for an overnight stay, please use the black house phone (inside the ICU Family Room) to dial:

x4-4092, between 7:30am - 8pm
x2-9111, between 8pm - 7:30am

Please obtain a sign-out card from the front desk in your unit after you have confirmed the room’s availability at one of the numbers above.

When you have obtained your sign-out card, please see the following people to obtain a key:
7:30am-8pm: BIDMC Ambassador, Clinical Center Lobby Desk
8pm – 7:30am: Public Safety, Farr 1.
Families on Rounds

Patients and Families need more direct communication with the team

What if we allow families to participate in multidisciplinary morning rounds?

ICU PFAC

BIDMC
Families on Rounds: 2 Cards Created for Family Members

Communicating with the ICU team

Communication with you is a very important part of our job here in the ICU. Different families prefer different amounts of information: some families like to know a lot of details, others don’t. Here are some ways that we communicate with you:

**Ask your nurse.** This is often the first, and best, place to start. Nurses in the ICU take care of 1 or 2 patients at a time. They spend a lot of time with their patients and know all the details of what is going on.

**Ask your doctors.** There is a team of ICU physicians caring for your family member. We have at least two doctors here 24x7. The best time to speak with them is usually in the afternoon, between 2:00pm and 5:00pm.

**Ask your social worker.** Social workers have helped other families with issues like: coping with the challenges of a loved one being ill and hospitalized, resources such as local lodging or how to get extra help at home, concerns related to alcohol or substance abuse, etc. Ask your nurse to call your social worker.

**Schedule a family meeting.** A family meeting is a time for you to meet with the care team and review what’s going on. It is protected time for communication about where we’ve been, where we’re going, and what to expect.

**Join us on Rounds.** We are trying something new. Usually, rounds include just the doctors, nurses, and other health care providers. We are piloting a program to include families who want to participate as part of rounds. If you think you might be interested in attending, read the information below explaining what rounds are and let us know if they are of interest to you.

**Rounds in the ICU**

**What are Rounds?** During “rounds” your family member’s nurse, the ICU physicians, and sometimes the respiratory therapist, pharmacist, or other members of the team review and discuss all aspects of your loved one’s care. Together, they build a plan for the day.

**When do rounds take place?**
8:30am – 1:00pm, seven days a week.

**When will the team round on my family member?**
The order of rounds varies daily based on patient needs, so we can’t predict exactly what time rounds on your family member will take place. If you tell your nurse you want to attend, we will make every effort to make sure we find you before we start rounding on your family member.

Joining rounds? Let us know!

- ☐ Yes, please include me in rounds.
- ☐ No, I’m not interested in rounds.
- ☐ I’m not sure*

*If you check “I’m not sure”, we will check in with you to answer any questions or concerns.

Please return this card to your nurse.
Tangible Outcomes of Patient/Family Engagement

✓ Elimination of “visiting hours”
✓ Family on Rounds: Orientation to being part of the team
✓ Development of educational materials
✓ Waiting Room Revitalization
✓ Improved ICU Signage
✓ ICU Patient and Family Website
✓ Advisors as Teachers: Critical Care Grand Rounds
✓ Advisors as Co-Investigators
✓ Creation of ICU Transition Guide Volunteer Role
Comments: Partnership in Caring

Staff Comments:

• “Perspective that we don’t usually get. I don’t really know what patients are really feeling.” - Physician Assistant

• “Collective wisdom of ‘us’ and the ‘us’ includes patients” - Nurse

Patient comment:

• “I see how much health care providers worry about error and how hard it is to talk about it.”
Patient and Family Engagement

PFAC
~100 Advisors
Our 5 PFACS represent only 10% of Advisor activity
Beyond the PFACs, Advisors...

- Are members of standing committees
- Consult on space design projects
- Consult on quality improvement projects
- Present at conferences, “rounds”, and staff trainings
- Provide feedback for web and print materials
- Participate in focus groups and research projects
- Round on patients
Partnering with Patient/Family Advisors Around Respect and Dignity

Delphi consensus convening

Care of the Family After Death
• Comfort Cart feedback
• “About Grief” handout
• Autopsy information sheet

Advance Care Planning
• Conversation Ready Committee
• Focus Groups on patient information
• Simulation trainings on “code conversations”
Voice of An Advisor

• Ways in which I participate
• Culture that supports my work
• How being involved impacts how I feel about the organization
• What works well
• Areas for improvement in the future
The BIDMC Experience
What is the BIDMC Experience?
A focus on the staff, patient, and visitor experience

• How are you treated?

• How do you treat others?

• Is it always with dignity and respect?
  – Do we all have the same definition of dignity and respect?

• What does our data show?
We can be better

Currently, we are not the leader we believe we should be on the patient, employee and provider experiences.

41st Percentile
National Academic Healthcare Average
Employee Engagement

59th Percentile
PG Global Rating (9+10- FY’18 ytd) 0-100 Percentile
Patient Experience

52nd Percentile
Burnout or have Symptoms of burnout
Provider Experience

Good, not consistently great
What Does Respect Look Like?

❖ “Codifying the Practice of Respect”
  ❖ identifying, putting into words, getting into writing
  ❖ actions and behaviors that reflect or demonstrate our culture of respect

❖ When we are walking through the halls, what do we notice?
❖ What about when we interact with our colleagues, patients and families?
❖ What behaviors would demonstrate respect to our visitors as well as to each other?
Practice of Respect
Understanding our Current State

Voicing truth to our Disrespectful behaviors

Invisible
Not included/Excluded
Left alone in exam room
I have a name
Not involved in decisions about my work
Not just a means to an end
Tired of being told my work isn’t important

Gossip
Eye-rolling
Covering up, assigning blame
Undermining by talking negatively
Not valuing time

Not listening to other POVs, shutting down ideas
Speaking over someone, interrupting
Not even acknowledging my presence, looking at phones
Lack of responsiveness, Throwing equipment

Talking down to someone due to role or race
Starting a statement with “no disrespect meant...”
Lack of humility
Stereotypes and assumptions
The Road to a Respectful Culture
Roadmap for a Respectful Culture...

**Codification/Behavioral Theme**

- **Respect all roles**
  - Demonstrate that you value diversity of voices
  - Foster teamwork
  - Ask for and accept help when needed and anticipate others' needs

- **Show positive regard and assume the best**
  - Listen to understand
  - Give others your full attention
  - Assume the best
  - Value people's time
  - Honor the workspace environment

- **Demonstrate compassion**
  - Acknowledge and attend to others
  - Be compassionate and empathetic
  - Show gratitude
  - Apologize

- **Self awareness and humility**
  - Demonstrate via body language, choice of words and tone of voice
  - Be open to giving and receiving feedback
  - Consider how your actions/words will affect others
  - Be aware of unconscious bias

**Promoting Behavior**

- Intentionally engaging and including all constituents by participation and information sharing
- Spending time with people
- Introducing new employees via walkabouts through the department
- Saying thank you

**Undermining Behavior**

- Reaching out only when there is a need
- Shutting down ideas without further questioning/exploration
- Micromanaging
- Showing bias against other specialties or colleagues

**Promoting Behavior**

- Asking questions
- Listening more, talking less
- Paraphrasing to check understanding
- Coming up with at least 3 possible rationales for an action

**Undermining Behavior**

- Speaking negatively about others
- Not acknowledging someone’s presence
- Interrupting
- Blaming others

**Promoting Behavior**

- Making eye contact
- Saying “hi” to everyone
- Helping those who are lost
- Smiling
- Show gratitude frequently

**Undermining Behavior**

- Avoiding eye contact
- Ignoring people in hallway or at meeting
- Looking at phone entire meeting

**Promoting Behavior**

- Asking for and accepting help when needed
- Asking for feedback across, down, up

**Undermining Behavior**

- Minimizing the concerns of others
- Gossiping
- Raising your voice or using an accusatory tone
Lessons Learned

• Leadership buy-in and support (financial and personnel)
• Advisor partnership requires careful planning and execution
  ...and a willingness to relinquish some degree of control
• Consistent set of metrics allows change to be tracked over time
• Not all well-intentioned interventions are successful
  ...learn from flawed implementations, stay humble
• It takes a village...
“Don’t let fear cause you to avoid engaging patients; be present, value it. Change won’t be effective if it gets delegated, you have to be part of it. At the end of the day it has to be meaningful, it has to be about patients.”

Marsha Maurer
SVP, Patient Care Services, Chief Nursing Officer, BIDMC
Where we’ve been today...

• Recognizing & describing non-physical harm and disrespect
• RCA² approach to harm events to drive improvement
• Patient-family engagement integral to improvement

Where you’re going...

Leaving in Action
Framework for Safe, Reliable, and Effective Care

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Thank you for your attention!

Please take copies of the articles:
- Practice of Respect consensus statement
- Disrespect ➔ non-physical harm conceptual framework

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