The Role of Leadership & Culture in Patient Safety

Objectives

Describe the patient safety crisis in healthcare.

Define the difference between a manager and a leader.

Explore the importance of an organization's culture and the elements required to create a culture of safety, including Psychological Safety.

Differentiate between empowered and engaged health professionals.

Patient Safety Story

MEDICATION ERROR IN THE OPERATING ROOM

Medication Error in Operating Room

Personal experience

A medication meant for topical use was injected locally to a patient.

Patient experienced cardiac arrest and was resuscitated and recovered with minor memory issues.

Factors that led to error:

Surgeon had little to no relationship with team.

Staff felt rushed by surgeon and hurried through several steps to get ready.

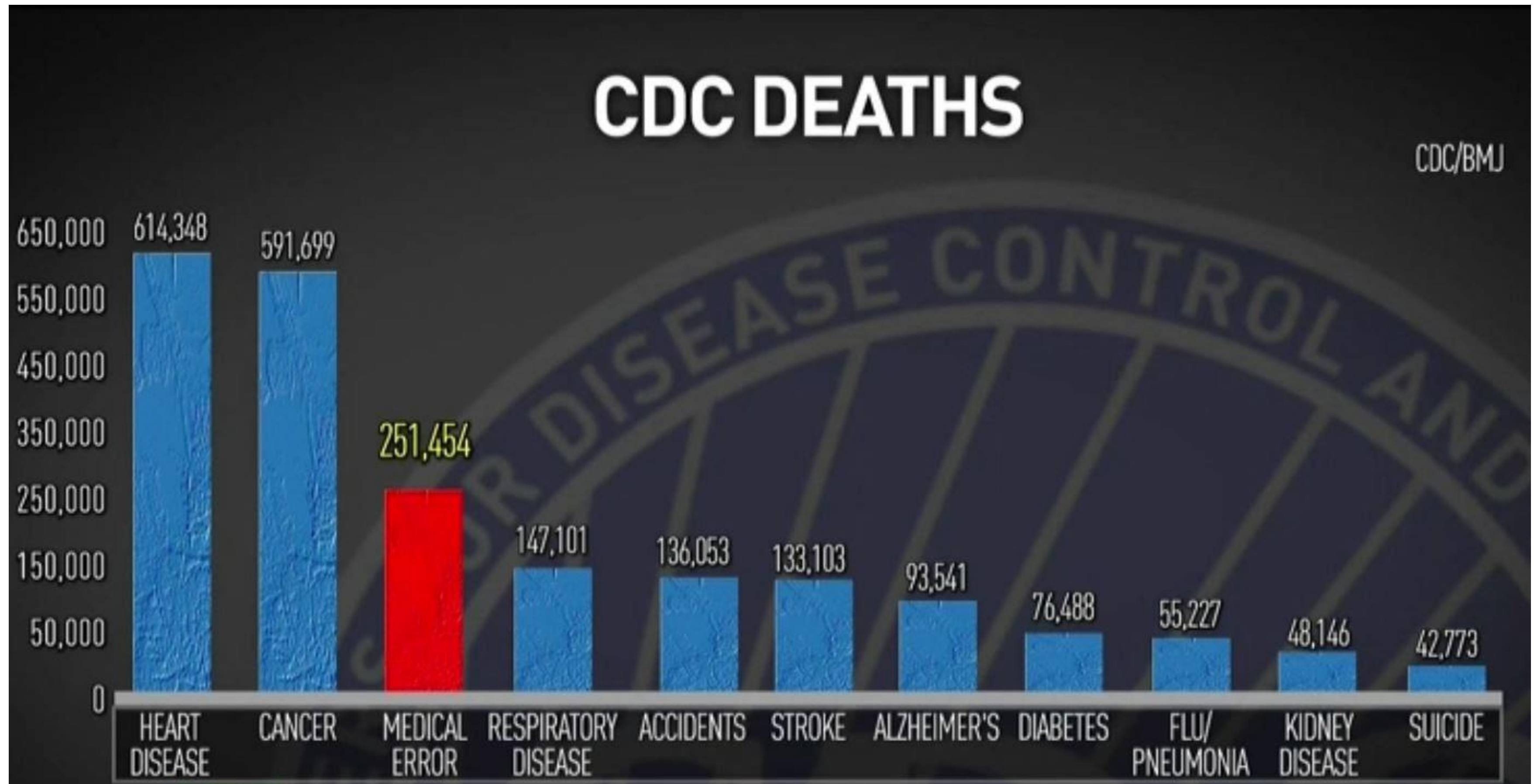
Communication in room was poor.

Surgical technician knew something felt wrong, but was uncomfortable stopping the surgery.

The Patient Safety Crisis

Medical Error Numbers

Source: CDC/British Medical Journal 2016



Patient Safety Statistics

Both the number of incidents and the dollar amount is significant.

Source: National Patient Safety Foundation Progress Report 2014-2015

Why Patient Safety?

Medication errors harm an estimated **1.5 million** Americans each year, resulting in more than $3.5 billion in additional medical costs.

About **1 in 25** US patients suffers at least one infection contracted during the course of their hospital care.

About **1 in 10** US patients experiences an adverse condition, such as a pressure ulcer or a fall, during hospitalization.

In the United States each year there are

611,100 deaths from heart disease

574,800 cancer-related deaths

44,000 to **440,000** estimated deaths from preventable medical errors in hospitals

Unkind Cuts

Surgery problems in the U.S. by the numbers

39 The number of times a week a surgeon leaves a foreign object such as a sponge or a towel inside a patient's body after an operation.

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20 The number of times a week a surgeon performs the wrong procedure on a patient.

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20 The number of times a week a surgeon operates on the wrong site.

157,000 The number of surgical-site infections in 2013.

Sources: Johns Hopkins, Surgery; Centers for Disease Control and Prevention

THE WALL STREET JOURNAL

Risk of Harm

According to the World Health Organization:

1 in 1,000,000:

The risk of being injured during air travel.

1 in 300:

The risk of being harmed while in a healthcare setting.

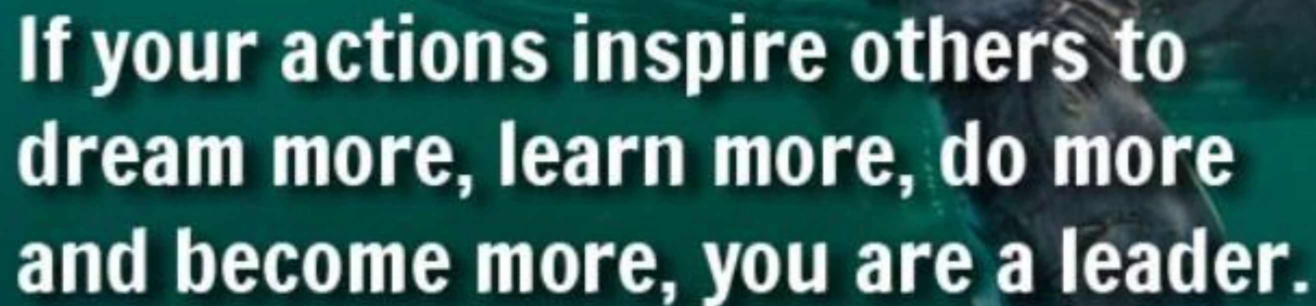
Individuals are far safer flying across the world than walking into a hospital.

Source: National Patient Safety Foundation

Leadership

PATIENT SAFETY STARTS WITH LEADERSHIP

What is Leadership?



Definition of Leadership:
John Kotter in his book Leading Change

Management is a set of processes that can keep a complicated system of people and technology running smoothly.

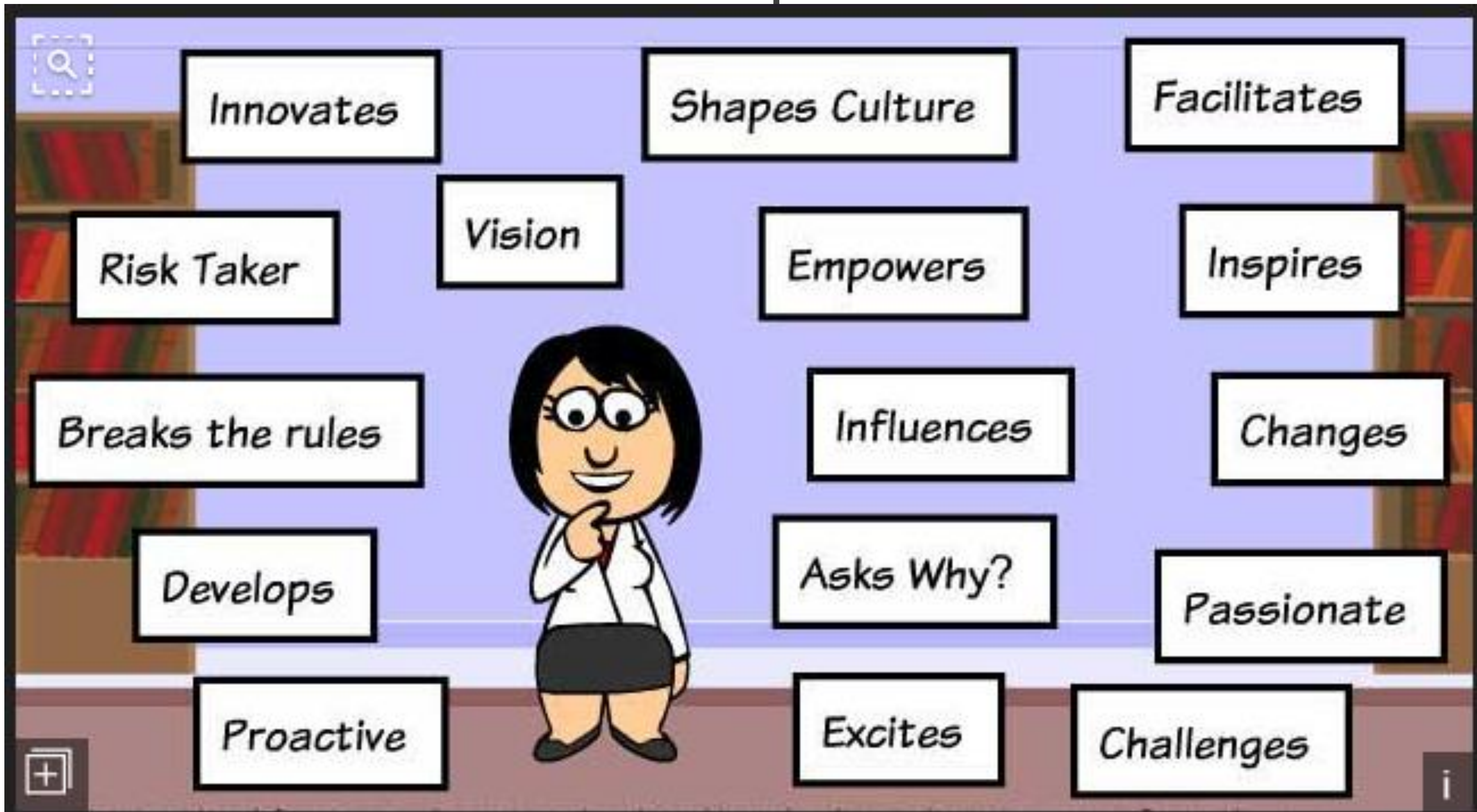
Leadership is a set of processes that creates organizations in the first place or adapts them to significantly changing circumstances. Leadership defines what the future should look like, aligns people with that vision, and inspires them to make it happen despite the obstacles.

Leadership vs. Management

From Peter G. Northouse's Leadership: Theory and Practice, Fourth Edition (2007) in which he draws from John Kotter's A Force for Change: How Leadership Differs from Management, (1990).

Leadership Produces change and movement	**Management** Produces order and consistency
1. Establishes direction ▪ Creates a vision ▪ Clarifies the big picture ▪ Sets strategies	1. Planning and budgeting ▪ Establishes agendas ▪ Sets timetable ▪ Allocates resources
2. Aligns people ▪ Communicates goals ▪ Seeks commitment ▪ Builds teams, coalitions and alliances	2. Organizing and staffing ▪ Provide structure ▪ Make job placements ▪ Establish rules and procedures
3. Motivates and inspires ▪ Energizes ▪ Empowers subordinates & colleagues ▪ Satisfies unmet needs	3. Controlling and problem solving ▪ Develop incentives ▪ Generate creative solutions ▪ Take corrective action

Leadership Attributes



Are Leaders Born?

"The most dangerous leadership myth is that leaders are born – that there is a genetic factor to leadership. That's nonsense; in fact, the opposite is true. Leaders are made rather than born."

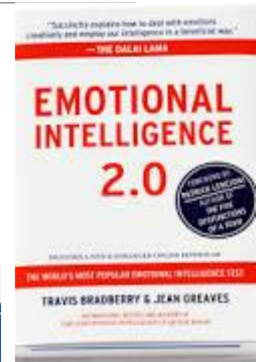
Warren Bennis,
Leadership Scholar

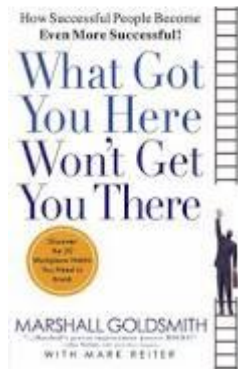
Leadership Can Be Taught

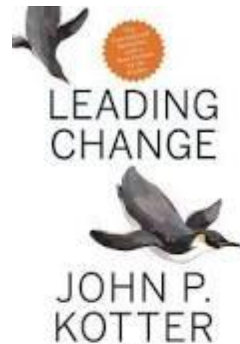
- Some individuals are born with leadership traits
- Most great leaders are developed
- Mentoring/Coaching
- Self-awareness
- Study
- Experience – Good & Bad

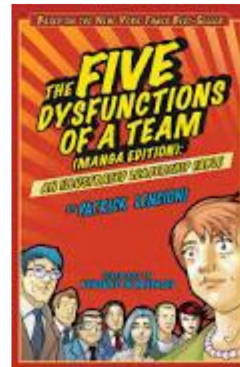
Training Options

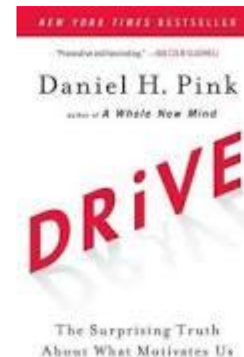
- Emotional Intelligence 2.0 by Talent Smart, Inc.
  - Personal Competence – Self Awareness & Self Management
  - Social Competence – Social Awareness & Relationship Management

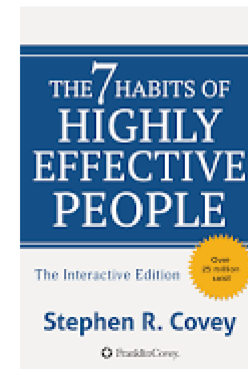












Types of Leadership

- Laissez-Faire
- Autocratic
- Participative or Democratic
- Transactional
- Transformative
- Servant

I never thought
in terms of being a
LEADER
I thought very simply
in terms of helping
PEOPLE

–John Hume

MOTIVATIONAL PICTURE QUOTES.COM

Servant Leadership

Term introduced by Bob Greenleaf in 1970 – Top AT & T executive – Greenleaf.org.

Effective leaders need to serve their people first.

The conscious choice to serve, then transitions into leadership.

Characteristics of Servant Leadership

- Active Listening – provide feedback to ensure understanding of the message.
- Empathy – understanding the emotions of the team.
- Healing Relationships – create sense of well-being.
- Awareness – understand how environment & issues affect the organization.
- Persuasion vs. authority or coercion.

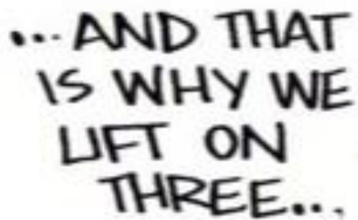
www.Greenleaf.org

Characteristics of Servant Leadership

- Conceptualization – turn values & goals into strategies & objectives.
- Foresight – foresee consequences of events/actions on organization.
- Stewardship – caretaking role vs. dominion.
- Development of individual – personally committed to growth of individuals.
- Commitment to building a community – create mutual commitment.

www.Greenleaf.org

Culture of Safety


...AND THAT IS WHY WE LIFT ON THREE...
COMMUNICATION
DOLIGHAN
dolighan.com

WHAT IS YOUR CULTURE?

The culture of an organization is often described as "the way we do things around here." In recent years, it is recognized that a Just Culture of patient safety is essential if physicians and other healthcare workers are to provide safer care.

Canadian Medical Protective Association

Culture of Safety Definition

The concept of safety culture originated outside health care, in studies of high reliability organizations, organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work.

Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality. Studies have documented considerable variation in perceptions of safety culture across organizations and job descriptions.

Safety Culture | AHRQ Patient Safety Network

psnet.ahrq.gov/primers/primer/5/safety-culture

Word Picture of Culture of Safety

Canadian Medical Protective Association

A just culture of safety — what is it?

Culture of Safety

Acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations.

A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment.

Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems.

Organizational commitment of resources to address safety concerns.

AHRQ https://psnet.ahrq.gov/primers/primer/5

Elements of a Safe Culture

- Leaders visibly committed to change
- Leaders provide resources to enact change
- Consistent and sustained message from leadership on importance of safety
- Transparency - Open sharing of information
- Systems approach
- Non-blaming environment
- Learn from mistakes
- Engaged staff

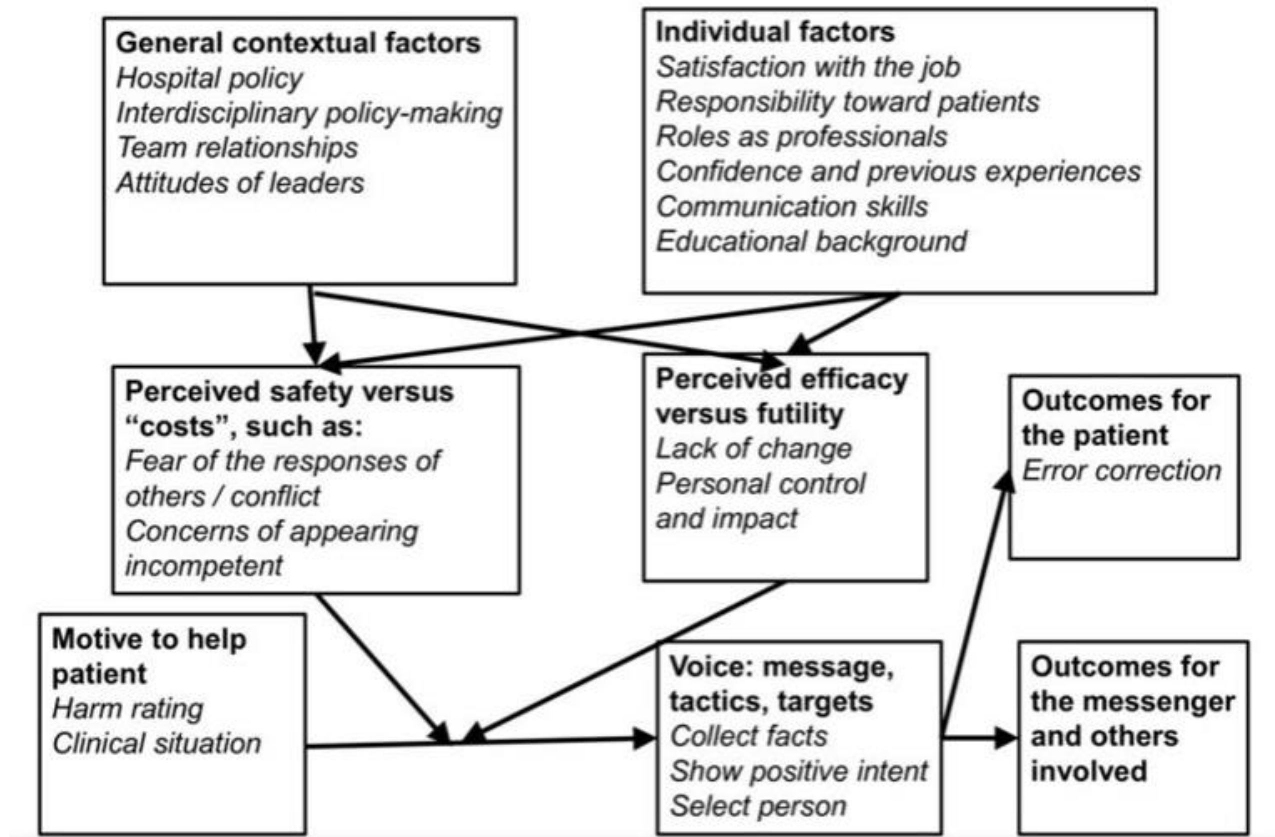
IHI Institute for Healthcare Improvement

Elements that Challenge a Safe Culture

- Hierarchy in medicine
- Psychological harm
- Disengaged staff
- Lack of transparency
- Uninvolved or inconsistent leadership
- Lack of clear behavioral expectations

Why Don't People Speak Up?

Morrison Model of Employee Voice: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-61



Psychological Safety Elements

Amy Edmondson, Harvard Business School Professor, Institute for Healthcare Improvement

- Anyone can ask questions without feeling 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.

- Organizations and individuals who show humility and ask each other questions create psychological safety.

Creating Psychological Safety

Institute for Healthcare Improvement – Amy Edmundson
Three Ways to Create Psychological Safety in Healthcare

- Frame the work
  - Add meaning to the work
  - Remind people of the nature of the work
- Model fallibility – we all make mistakes
  - “I may miss something. I need your help”
  - Invite input – ask questions
- Embrace messengers
  - Thank those who say something

Ultimate Goal
Improved Communication

"Communication is essential in a healthy organization. But all too often when we interact with people—especially those who report to us—we simply tell them what we think they need to know. This shuts them down. To generate bold new ideas, to avoid disastrous mistakes, to develop agility and flexibility, we need to practice Humble Inquiry."

"The purpose of Humble Inquiry is to build relationships that lead to trust which, in turn, leads to better communication and collaboration"

Edgard H. Schein, Humble Inquiry The Gentle Art of Asking Instead of Telling

How Humble Inquiry Works

Doctors think: “Professionals” will speak up

Staff think: doctors are allowed to create a climate which prevents speaking up.

“Telling” puts the other person down.

“Asking” can temporarily empower the other person – Here & Now Humility.

Good communication requires building trusting relationships, which requires asking questions – Humble Inquiry.

When you are dependent on someone to get a task accomplished, it is essential to build a relationship with that person that will lead to open task-related communication.

Why is Humble Inquiry so Difficult?

Achievement – oriented culture which values knowledge and the display of knowledge.

Hierarchical nature of medicine discourages humility.

De facto dependence on “lower-status” team members.

Checklists and standardized training are necessary but not sufficient – in new & ambiguous situations, team members will fall back on their own cultural rules & do unpredictable things.

Importance of Leadership & Communication to Patient Safety

Patient safety depends on:

- Creation of a safe culture to speak up
- Leadership which supports staff who speak up
- Leadership which sets a positive example
- Effective, safe communication across hierarchies
- Respect, trust, humility & mindfulness
- Recognition of mutual interdependency
- Humble Inquiry – listening more, telling less (Schein, E. 2013)

Employee Engagement vs Empowerment

Employee Empowerment

Employee empowerment is giving employees a certain degree of autonomy and responsibility for decision-making regarding their specific organizational tasks

- Empowered employee can free up managers from some duties
- They feel more satisfied and productive in their own roles
- Can revert to disempowered behavior in stressful situations

Kevin Kruse, Forbes.com

What’s the Difference?

Employee engagement is the emotional commitment the employee has to the organization and its goals.

This emotional commitment means engaged employees actually **care** about their work and their company. They don't work just for a paycheck, or just for the next promotion, but work on behalf of the organization's goals. They make stronger efforts with their colleagues and clients.

Engaged Employees:

- **Display enthusiasm and optimism for the organization**
- **They believe they can make a positive impact**
- **Their positivity and loyalty can be infectious**
- **Display an emotional commitment**

Kevin Kruse, Forbes.com

Steps to Build a Company of Engaged & Empowered Employees

Provide adequate training to equip employees with the knowledge and awareness to make effective, accurate, timely decisions;

Establish open and honest lines of communication so employees can speak to managers without fear of reprisal;

Provide ongoing, consistent feedback to all employees and managers so all staff better understand what is expected within their role;

Keep employees "in the loop"—about company goals, forecasts, and changes— so they can see "the big picture";

Have confidence in other people's decision-making and trust their competencies. **Engaged** and **Empowered** employees feel their skills are utilized and appreciated.

Kevin Kruse, Forbes.com

Commitment to Patient Safety

WHAT CAN I DO AS A LEADER

Providing Leadership for Patient Safety

Introduce & Implement the following communication & leadership skills in the workplace:

- Listen more and tell less.
- Ask the right questions.
- Here-and-now Humility – removes hierarchy in interdependent teams.
- Humble Inquiry – asking questions which build a relationship based on curiosity and interest in the person.
- Creation of culture of psychological safety, which allows all team members to speak up across hierarchical boundaries – RN and surgeons can communicate respectfully in OR.

(Schein, 2013)

Leadership's Role in Patient Safety

- Direct interaction with frontline staff – Leadership rounds.
- Setting an example for the rest of the team.
- Engagement with staff/surgeons who voluntarily report errors.
- Management of disruptive and unprofessional behavior by clinicians – respond early.
- Commitment to a Just Culture of Safety.

AHRQ – Leadership Role in Improving Safety

https://psnet.ahrq.gov/primers/primer/32/organizational-leadership-and-its-role-in-improving-safety

Changing Your Culture of Safety

- Measure your organization's culture of safety – take a survey on AHRQ.
- Include everyone in the organization.
- Require surgeon participation.
- Agree on your culture definition.
- Discuss the importance consistently and persistently.
- Provide leadership to your staff.
- Engage your staff.

National Resources

Patient Safety Movement– collaborative effort by all stakeholders to achieve zero preventable deaths by 2020: http://patientsafetymovement.org.

National Patient Safety Foundation - Central voice for patient safety: www.npfs.org.

Mothers Against Medical Error –provide emotional support for victims of medical harm: http://mamemomsonline.org/.

AHRQ Agency for Healthcare Research and Quality – national research on patient safety initiatives: https://pso.ahrq.gov/. TeamSTEPPS.

The Joint Commission – accreditation agency promoting and surveying patient safety: https://www.jointcommission.org/topics/patient_safety.aspx.

Resources

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Employee Voice and SilenceElizabeth W. Morrison
Department of Management and Organizations, Leonard N. Stern School of Business, New York University, New York, NY 10012; email: emorriso@stern.nyu.edu

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