Leadership in Crisis

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Leadership Fundamentals

• Relentless adherence to our values.
• Celebrate victories
• Tenacious focus on quality, safety, errors a.k.a. reliability.
• Habitual Excellence – Paul O’Neill
  – Fundamental non-negotiable respect for all in the organization - regardless of pay grade, title, race, ethnicity, religious beliefs or gender
  – Have tools, resources and encouragement to do one’s job.
  – One’s work is recognized.
Two Models of Leadership In System Change

Leadership as a position

We have authority. We know what we want and how to get it. We can show you how to do it. We can help if you get stuck.

1. Speaking from authority
2. Telling
3. Education
4. Audit compliance
5. Technical assistance
6. Problem solving

Leadership as a function

We all know the outcome we want and we know it is possible. It is beyond our individual reach. We have to figure out how to do it together.

1. Standing for a compelling future
2. Speaking to enroll
3. Co-accountability
4. Co-create
5. Action learning
6. Adaptability

Storytelling

• “Storytelling is the single most powerful tool in a leader’s toolkit.” – Howard Gardner, Changing Minds

• “Storytelling is about translating our values into emotions that enable us to act.”
  - Marshall Ganz, Kennedy School

• “Changing behavior is less a matter of giving people analysis to influence their thoughts than helping them to see a truth to influence their feelings… the heart of change is in the emotions.”
  – John Kotter, The Heart of Change
Preventable Harm Events

Fiscal Year 2013 Goal: Reduce Preventable Harm by 50%

Patient Safety

- Falls with Injury: 28
- Ventilator Associated Pneumonia: 2
- Serious Med Errors: 6
- Surgical Site Infections: 2
- CLABSI: 0

2013 total: 108
2014 Goal: 54
2015 Goal: 38
2016 Goal: 27
2017 Goal: 0

Patients:
- Judy, age 86
- Jane, age 56
- Jim, age 48
- Kevin, age 50
- Rob, age 76
- Sam, age 90
- Susan, age 62
- Bill, age 77
- Rose, age 89
- Frank, age 88
- Chris, age 87
- Linda, age 84
- Karen, age 45
- Susan, age 28
- Sal, age 80
- Lisa, age 60
- Tim, age 76
- Doug, age 72
- Karl, age 33
- Felicia, age 80
- Matthew, age 89
- Leo, age 80
- Paul, age 67
- Peter, age 78
- Raymond, age 54
- Jim, age 48
- Raymond, age 54
Addressing Complexity and Reliability in Patient Safety
Complex Adaptive Systems (CAS)

- Characteristic of embedded CAS’s
- Importance of diversity
- Nonlinear – possibility for a small change to have a large impact
- Distributed control vs. centralized control – “self organization”
- Importance of patterns
- Focus on relationships

What is Reliability?

• Definition:
  – "... the ability of a process or component to perform its required functions under stated conditions for a specified period of time”

  – What information is needed in order determine if a process is ‘reliable’?
Characteristics of High Reliability Organizations (Weick & Sutcliffe)

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise
Managing the Unexpected (Weick & Sutcliffe)

• “Mindfulness”:
  o Ability to see the significance of early and weak signals and to take strong decisive action to prevent harm

• “Sensemaking”:
  o Process of transforming experiences into updated views of the system by “taking the time to make sense out of new and changing circumstances”
  o “Trust is a product of sensemaking.” – J. Morath
Engaging Front-Line Staff in Safety

- Focus on the systems of care and on redesigning work processes
- Must involve “sharp end” caregivers
- Education and training alone will not work – requires increased “mindfulness”
- Cultural change requires strong leadership
- Must improve reliability through new approaches
- Make it personal
PfP Four Calls to Action

• **Reduce harm across the board.** It is a call for hospitals to produce reductions in every type of harm.

• **Take a systemic approach.** It is a call to transform the organization and its practices to eliminate all the causes of harm. “Using every means at our disposal.”

• **Make your safety transparent to all.** It is a call for hospitals to define themselves by their safety performance; define themselves to their employees, doctors, patients and the community.

• **Make safety personal & compelling.** Make every incident of harm a personal patient story that propels the institution to higher levels of performance.
What do patients want when an adverse event occurs?

1. Know what happened
2. Receive an apology
3. Be assured the hospital is doing all it can to prevent a recurrence

Lucien Leape, MD
Apology and Disclosure

• Massachusetts Coalition for the Prevention of Medical Errors and the Harvard hospitals

• When Things Go Wrong:
  ➢ http://www.macoalition.org/documents/respondingToAdverseEvents.pdf
The Leadership Challenge

• Model the Way
• Inspire a Shared Vision
• Challenge the Process
• Enable Others to Act
• Encourage the Heart

The Leadership Challenge
Kouzes and Posner, 2002