MHCSA Education

September 13, 2018, 12 Noon to 1pm Eastern

MHCSA Presentation - HRO: A Layered Approach

12 Noon - 1pm

Phone: **1-415-655-0001**

Meeting No: **648 254 824 #**

The presentation has a DIFFERENT meeting number.
See your mhcsa-list@mhcsa.org e-mail for the link to view the presentation.

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HIGH RELIABILITY ORGANIZING: A LAYERED APPROACH

Amy Anyangu RN

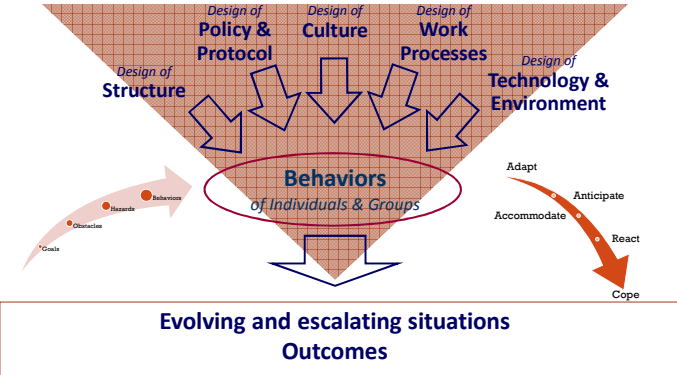Director, Safety and HRO Development

SCL Health   Denver, CO

OBJECTIVES

- Provide an overview of reliability in healthcare
- Discuss critical components of reliability in healthcare
  - Individual reliability
  - Team reliability
  - Organizational reliability
- Discuss emphasis on culture within high reliability organizing

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RELIABILITY IN A COMPLEX NUTSHELL

Design of **Policy & Protocol**   Design of **Culture**   Design of **Work Processes**

Design of **Structure**

Design of **Technology & Environment**

Behaviors *of Individuals & Groups*
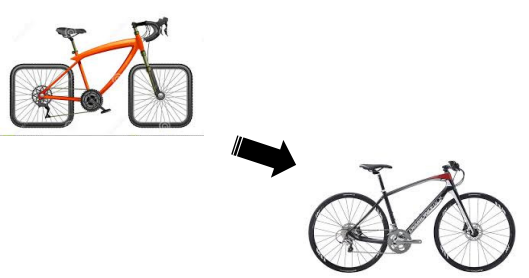
Goals · Obstacles · Hazards · Behaviors

Adapt · Anticipate · Accommodate · React · Cope

**Evolving and escalating situations
Outcomes**

Adapted from R. Cook and D. Woods, *Operating at the Sharp End: The Complexity of Human Error* (1994)
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VISION FOR RELIABILITY

HOW DO WE GET THERE?

Reliable People

Competency
Consciousness
Communication
Critical Thinking
Compliance

Reliable System

Structure
Culture
Process
Policy and Protocol
Technology and Environment

High Reliability Organizing

HEALTHCARE AND AVIATION ARE INTERCHANGEABLE INDUSTRIES WITH THE ABILITY FOR DIRECT APPLICATION OF PRINCIPLES AND SUCCESSES IN RELIABILITY?

HIGH RELIABILITY ORGANIZING

HROs "operate under very trying conditions all the time *and yet manage* to have fewer than their fair share of accidents."

3 Principles of Anticipation *"Stay Out of Trouble"*

Sensitivity to Operations
Preoccupation with Failure
Reluctance to Simplify

2 Principles of Containment *"Get Out of Trouble"*

Commitment to Resilience
Deference to Expertise

LAYERS OF RELIABILITY

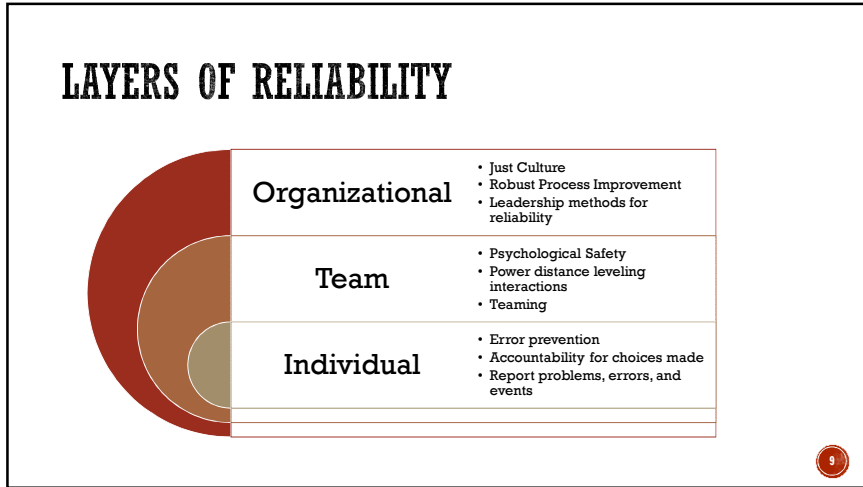| Organizational	• Just Culture • Robust Process Improvement • Leadership methods for reliability
Team	• Psychological Safety • Power distance leveling interactions • Teaming
Individual	• Error prevention • Accountability for choices made • Report problems, errors, and events

Individual Reliability

IN ORDER TO REACH HIGH RELIABILITY WE MUST ELIMINATE ERRORS.

INDIVIDUAL RELIABILITY: ERROR PREVENTION

Skill Based Errors
• Auto Pilot Mode
• Routine, familiar tasks

Rule Based Errors
• If-Then Response Mode
• Respond to a situation using rule we were taught or learned through experience

Knowledge Based Errors
• Figuring-it-out Mode
• Problem solving in an unfamiliar situation

INDIVIDUAL RELIABILITY: ACCOUNTABILITY FOR CHOICES MADE

Three Duties according to Marx:
▪ We are responsible to avoid causing unjustifiable risk or harm
▪ We are responsible to follow a procedural rule within the system
▪ We are responsible to produce an outcome for the system

We are accountable for our behaviors and choices

Optimal Accountability

Leaders *Vertical Accountability*

Individual *Intrinsic Accountability*

Peers *Horizontal Accountability*

INDIVIDUAL RELIABILITY:
REPORT PROBLEMS, ERRORS AND EVENTS

A Culture of Safety:

- No one is ever hesitant to voice a concern about a patient
- Skilled caregivers playing by the rules feel safe to discuss and learn from errors
- Concerns raised by front line caregivers are taken seriously and acted upon
- Action is taken, feedback reliably provided, changes are visible for associates and patients

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INDIVIDUAL RELIABILITY:
REPORT PROBLEMS, ERRORS AND EVENTS

We can't fix what we don't know about

It's about fixing the system so the right thing is the easy thing

Reporting is not punitive

"Every system is perfectly designed to get the results it gets"
—Donald M. Berwick, M.D.
Previous Administrator, Centers for Medicare & Medicaid Services *(CMS)*

Team Reliability

WITHIN MY CURRENT TEAM, I CAN SPEAK UP FREELY IF I HAVE A QUESTION, PERCEIVE A RISK, DISAGREE, OR HAVE A NEW IDEA.

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TEAM RELIABILITY:
PSYCHOLOGICAL SAFETY

- Psychological safety = the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes

- Four attributes of psychological safety
    1. Anyone can ask questions without looking stupid.
    2. Anyone can ask for feedback without looking incompetent.
    3. Anyone can be respectfully critical without appearing negative.
    4. Anyone can suggest innovative ideas without being perceived as disruptive.

	Comfort Zone	Learning Zone
Psychological Safety	Apathy Zone	Anxiety Zone

Low — Accountability — High

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PSYCHOLOGICAL SAFETY: HOW TO BUILD IT

1. Frame the work
   - Creates the rationale for speaking up
   - The nature of the work we do is uncertain and interdependent

2. Acknowledge your own fallibility – invite input
   - Creates safety for speaking up
   - Important leadership behavior
   - "I may miss something and I am counting on you to help me."
   - Embrace messengers by saying "Thank you"

3. Model Curiosity
   - Creates necessity for their voice
   - Ask a lot of questions, engage team members in decision making and problem solving

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TEAM RELIABILITY: POWER DISTANCE LEVELING INTERACTIONS

The *perceived* distance – not necessarily the real difference – as seen by the *subordinate*

Large Distance
- Relations are autocratic and paternalistic
- Power acknowledged based on formal, hierarchical positions

Small Distance
- Relations are consultative and democratic
- Relate as equals regardless of formal positions

Adapted from G. Hofstede's *Culture's Consequences* (2001)

TEAM RELIABILITY: TEAMING

- **Team**: bounded group of people who are interdependent in accomplishing a shared goal
- **Teaming**: process of coordinating and communicating to accomplish a goal
  - Teamwork on the fly
- **Teaming and patient safety**:
  - Without effective teaming, patient safety does not happen
  - Patient safety happens when we have very transparent, careful and mindful coordination of roles amongst professions and team members

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Organizational Reliability

A JUST CULTURE MEANS ALL ERRORS ARE CAUSED BY BAD SYSTEMS AND RESULTS IN A NO BLAME APPROACH.

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ORGANIZATIONAL RELIABILITY: JUST CULTURE

- Does NOT mean no blame
- "Every system is perfectly designed to achieve the results it gets." – Berwick
- "A bad system sets up good people." – Deming
- Individual error is a symptom not a cause
- Three Duties
- Looking for somewhere between survival of the fittest and Kumbaya

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ORGANIZATIONAL RELIABILITY: CREATING A LEARNING CULTURE

- Components of a Learning Culture:
  - Leadership
    - Fair, safe and accountable culture
  - Transparency
    - Strong reporting systems and ability to learn from failure
  - Reliability
  - Improvement and measurement
    - Learning must be visible
  - Continuous learning
    - Both proactive and reactive learning
    - Closure of feedback loops

Dear Past,
Thanks for all the lessons.
Dear Future,
I'm ready...
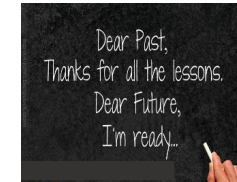
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ORGANIZATIONAL RELIABILITY: ROBUST PROCESS IMPROVEMENT

"We believe that three sets of process improvement tools – lean, six sigma, and change management – constitute the most effective way for health care to dramatically enhance its capacity to create nearly perfect safety processes." High Reliability Healthcare: Getting there from here. Chassen and Loeb, TJC 2011

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ORGANIZATIONAL RELIABILITY: ROBUST PROCESS IMPROVEMENT

Improvement Methodology (Q) #1
Business improvement efforts need to have a methodology (e.g., Lean/DMAIC) that matches their desired outcome and helps them get to the right "answer."

Yet, having the right "answer" or solution is only part of the story…

#2 **Accelerating Change & Transitions™ (A)**
… as you also need people to accept this solution. Paying attention to the human side of change significantly increases the likelihood that a solution will be utilized to its maximum potential.

Project Management #3
A foundational understanding of the SCL Health project management approach and standard tools/templates enables critical thinking and insightful decision making, reducing risk and improving success rates.

#4 **Facilitation Skills for Leaders™**
To work effectively with and through others, people must have sound facilitation skills to ensure all that the knowledge and expertise in the project team is fully utilized.
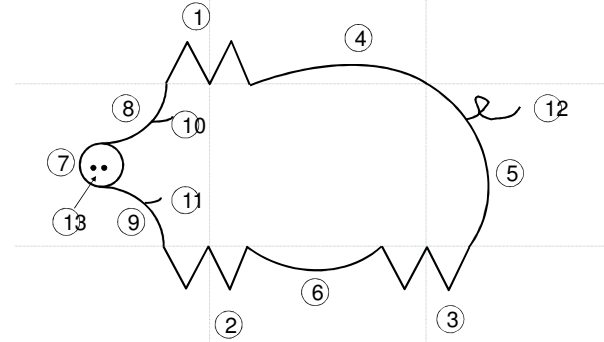
We will put the right tools in the hands of the right people at the right time to solve the right problems.

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PIG EXERCISE
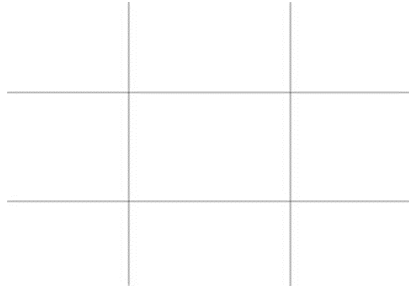
ORGANIZATIONAL RELIABILITY: LEADERSHIP METHODS FOR RELIABILITY

- Demonstrate a commitment to safety and reliability
  - Link decisions to safety
  - Encourage reporting of errors, problems and events
  - Thank and support those who speak up for safety
  - Model Tones and Tools to decrease power distance and adopt behaviors for error prevention
- Reinforce a strong culture of safety and build accountability
  - Consistently round for outcomes and influence
  - Lead safety conversations
  - Practice 5:1 Feedback
  - Fair and just accountability
- Find and fix problems
  - Attend and lead daily safety huddles
  - Promote and support department huddles both clinical and non-clinical
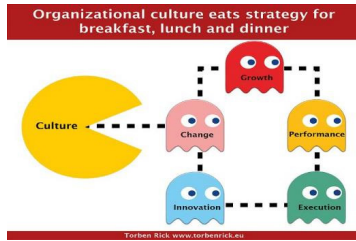
STEP 1: IDENTIFY THE PROBLEM
STEP 2: FIX IT

EMPHASIS ON CULTURE

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RELIABILITY AND CULTURE

- Great safety programs do not guarantee a culture of safety
- The best safety program in the world can be undermined by a dysfunctional culture.

Organizational culture eats strategy for breakfast, lunch and dinner

Growth
Culture
Change
Performance
Innovation
Execution

Torben Rick www.torbenrick.eu

WHAT DOES THE FUTURE LOOK LIKE?

Pockets of reliable people and systems but not widespread	Reliable people working in a reliable system
Over-reliance on experts/specialized resources in process improvement and project management	Effective problem solving and prioritization at all levels of the organization
Inability to spread learning from errors and events across the system	Preoccupation with failure/learning
Variation, errors, waste, drift	Standard processes, tools and methodologies that are sustained over time
Change is slow and democratic	System nimbleness/agility to organize for reliability any time
More time spent reacting	Anticipatory thinking/ability to "look around the corner"
Spotty alignment of systems and structures	Aligned/integrated systems and structures where associates and providers are educated, empowered and engaged in the pursuit of reliability
Struggle to stay current in the market	Innovation/leader in the market
Serious safety events and Associate injuries	Zero harm

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Thank You

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APPENDIX: PIG EXERCISE

THE PIG IS DRAWN ON THE NEXT SLIDE. VIEW THIS SLIDE IN PRESENTATION MODE AND IT WILL STEP YOU THROUGH HOW TO DRAW THIS PIG. BELOW ARE INSTRUCTIONS.

- 1. Draw a letter M at the top left intersection. Bottom center of M touches the intersection.

- 2. Draw the letter W at the bottom left intersection. Top center of W touches the intersection.

- 3. Draw the letter W at the bottom right intersection. Top center of W touches the intersection.

- 4. Draw an arc from the letter M to the top right intersection.

- 5. Draw another arc from the top right intersection to the bottom right W.

- 6. Draw an arc between the two bottom W's.

- 7. Draw the letter O in the center left box.

- 8. Draw an arc from the letter M to the tangent of the circle.

- 9. Draw an arc from the left W to the tangent of the circle.

- 10. Draw an arc for the eye. Half way between M and circle.

- 11. Draw an arc for the mouth. Half way between W and circle. Must be a happy pig!!

- 12. Draw the cursive letter e near the top of arc on the right.

- 13. And finally draw two dots in the middle of the circle for the pigs nose.

When you draw the demo make sure that your number the steps and tell everyone that this is the sequence which they must draw their pigs. This is the Standard Work for drawing a pig.