Making High Reliability Stick: The Top Ten Things Leaders DON’T Do in Healthcare

2012 High Reliability Organizing Conference
HPI – A Reliability Company

The One Vision
We lead the innovation that makes healthcare as reliable as it should be.

The Zero Mission
We create the Culture of Safety that achieves ZERO events of harm.

Six Aims for Improvement, Institute of Medicine
Top Ten Healthcare HRO Failures

1. Setting safety as a core value
2. Measurement of preventable harm
3. Making harm visible through transparency
4. Developing and implementing safety absolutes
5. Developing and implementing clear leadership expectations around safety and reliability
6. Learning through enhanced cause analysis
7. Setting clear expectations for safe practices
8. Building accountability for meeting practice expectations at the sharp end
9. Engaging physicians in safety culture ownership while holding them accountable for meeting practice expectations
10. Fair and just accountability implementation by leaders to ensure honest errors are not punished while attaching consequences for choices not to comply
Safety as Our Core Value
A Powerful Driver of Individual Decision Making

The loudest message wins...
Making Safety an Explicit Core Value

- Begin every meeting with safety
- Thank people for reporting
- Set the tone…
  - Greetings – include first names
  - Cordiality, openness
  - Eye contact and body language
- Team goals
  - Use “we” and “us” vs. “I” and “you”
  - What’s best for the patient…
- Invite a Questioning Attitude
  - Leaders set the tone for the flow of information
  - “If any member of the team sees anything that is unsafe, I expect you to speak up…”
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Reliability – Naval Aviation

- 776 aircraft destroyed in 1954
- 15 aircraft destroyed in 2008

Source: www.safetycenter.navy.mil ORM Flight Mishap Rate
A deviation from generally accepted performance standards (GAPS) that...

**Serious Safety Event**
- Reaches the patient
- Results in moderate to severe harm or death

**Precursor Safety Event**
- Reaches the patient
- Results in minimal harm or no detectable harm

**Near Miss Safety Event**
- Does not reach the patient
- Error is caught by a detection barrier or by chance

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1000 Bed Hospital – Midwest US

SSER JAN 2005: 1.21
SSER JAN 2007: 0.34 71.9% reduction

Event Rate

Number of Events

Jan-05  Mar-05  May-05  Jul-05  Sep-05  Nov-05  Jan-06  Mar-06  May-06  Jul-06  Sep-06  Nov-06  Jan-07  Mar-07
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Making Harm Visible in Naval Aviation
Making Harm Visible in Healthcare

...and more importantly, efforts to eliminate it!

- This report should be required reading for all leaders, staff and physicians!
- A leadership focus should be on getting this information to staff.
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What Is A Red Rule?

An act having the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time.

“Red” designates the rule as a safety absolute with the highest priority for exact compliance.
Georgia Tech vs Wake Forest

The Virginian-Pilot
PilotOnline.com

March 19, 2010

Low flyover lands two Oceana pilots in hot water
Red Rules are Not New Rules, but Are Flags on a Few Existing Rules

Focus attention and align beliefs around these acts as safety critical

Elevate acts to ingrained work habits to achieve highest level of compliance and reliability
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Leadership Triple Threat for Performance Reliability

Set the set point

Define & Demonstrate Core Values at the “blunt end”

Find Problems & Fix Causes in systems and processes

Manage to prevent, detect, and manage drift

Reinforce & Build Accountability for behaviors at the “sharp end”
Daily Safety Call
to share situational awareness

What it is: A huddle of the leader and direct reports at the start of the day to maintain awareness of operations and to give direction about priority and responsibility for problem resolution.

15 Minutes • Focused • On Feet

Senior Leader Daily Check-In Agenda
1. Significant safety, quality, or service concerns from last 24 hours/last shift
2. High-risk, out-of-the-norm activities or issues anticipated in next 24 hours/next shift
3. From the leader: Critical Questions for Safety & Quality
Admiral’s Daily Update in the U.S. Navy

- Brief to the Battlegroup Commander
- 9:00-9:30 am, everyday at sea
- All Department Heads
- Held live & via video teleconference
- 100% attendance expected - entire day’s schedule (Battle Rhythm) revolves around update
- Allows for real-time guidance and resource allocation

Sensitivity to Operations
Round to Influence (RTI)
a High Impact/Low Investment Leadership Method

A technique for reinforcing a vital behavior or performance expectation linked to a core value

- Focused on building a culture of reliability that creates safety… and quality, satisfaction, financial performance, etc.

- The key word in RTI is Influence
RTI on the Flight Deck
FOD Walkdown
Two sources of leader discomfort when rounding:
- Unfamiliar environment/process
- “Difficult” subject

Purposeful rounding at Helen DeVos Children’s Hospital:
1. Specific topics for Safety Rounds
2. All in it together – everyone focuses on same topic
3. Scripts with facts and stories
4. “Round to Influence”
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