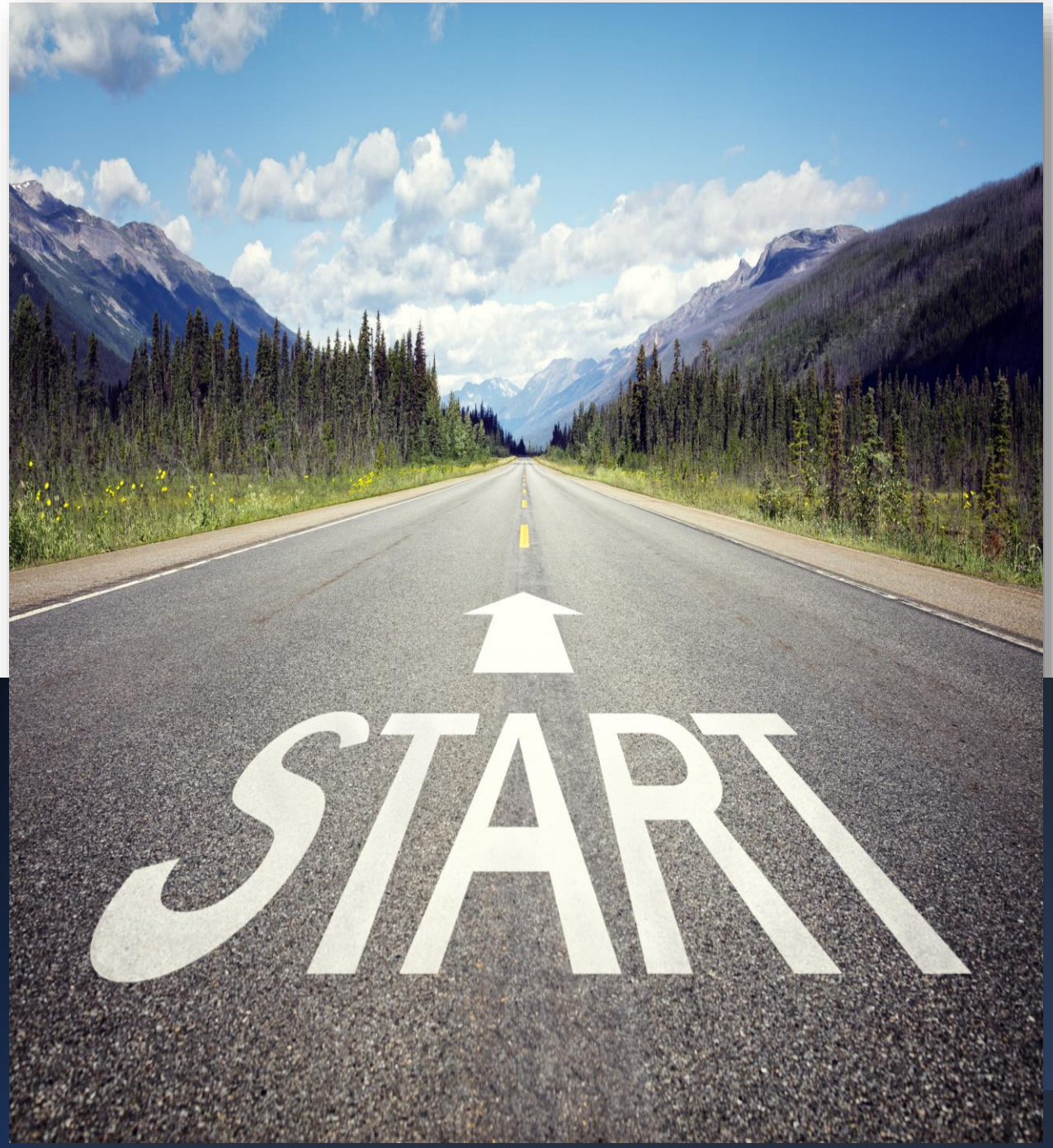
The Journey to Zero Harm Starts with Shared Learning & An Atmosphere of Trust



Amanda Cackler, DNP, RN, CIC, CPHQ

Director Quality & Safety

The University of Kansas Health System

Learning Objectives

Describe	Describe the components of a culture of safety
Explain	Explain the relationship between employee engagement and a safety culture
Identify	Identify three strategies for enhancing the journey to zero harm at your organization

What an Interesting Time to be a Healthcare Leader

- Recruiting and Retaining Talent
- Complexity of Health Care Needs
- Access to Health Care
- IT Transformation
- Respiratory Viruses
- Cybersecurity
- Insurers, Payers, Reimbursement
- Culture of Safety
- Everything Else

In an Industry Designed to Heal…

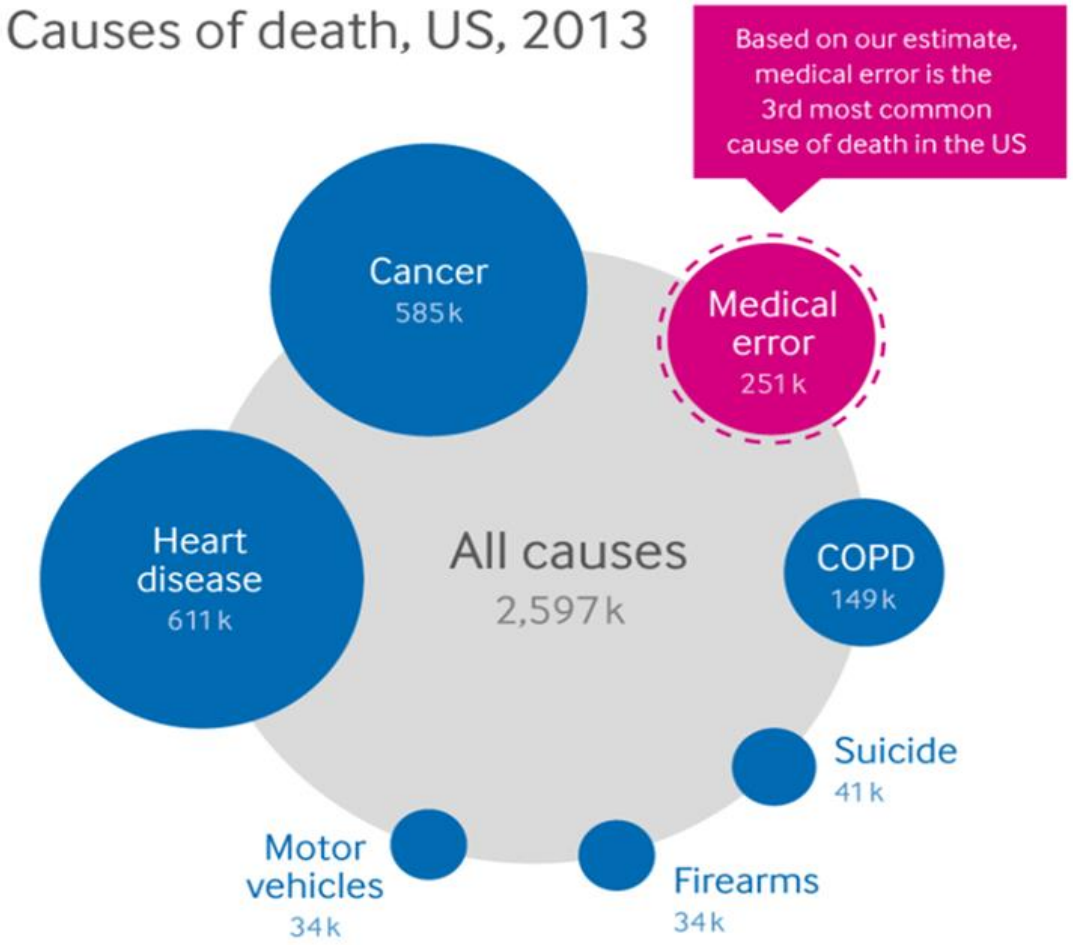
"There are some patients whom we cannot help; there are none whom we cannot harm."

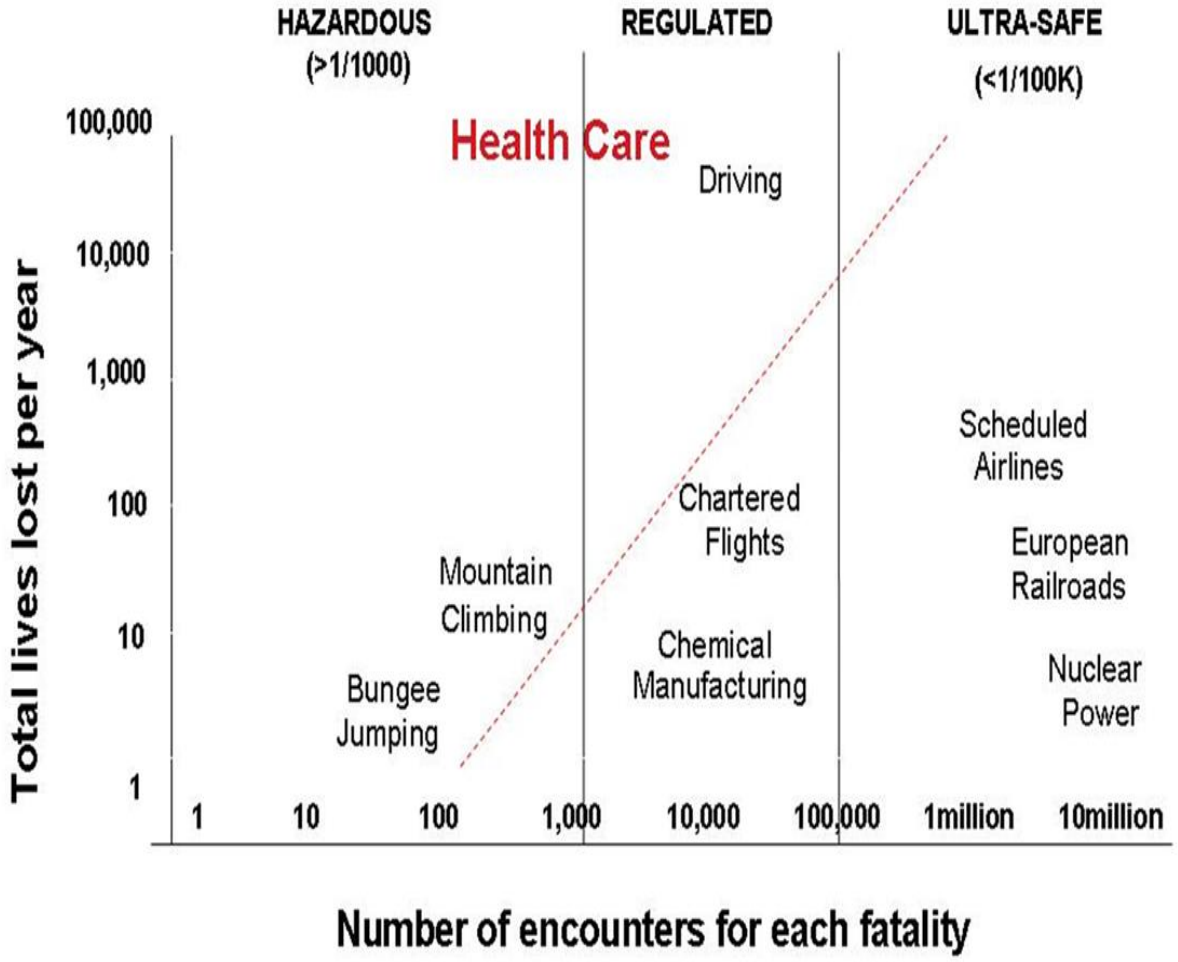
➢A.L. Bloomfield, JAMA


Each system is perfectly designed to give you exactly what you are getting today.
W. Edwards Deming
quotefancy

“Each system is perfectly designed to give you exactly what you are getting today…”

W Edwards Deming





“Each system is perfectly designed to give you exactly what you are getting today…”

W Edwards Deming

Potential Patient Safety Events

- A meal tray is delivered to the wrong patient with a specialized diet
- A surgical towel is unintentionally left inside a patient during a surgical procedure
- A specimen was labeled incorrectly, resulting in a diagnosis for the wrong patient
- A patient falls and breaks their arm while admitted under our care
- A patient is billed for treatment they didn’t receive
- A patient is transported to a procedure that wasn’t ordered for them

Potential Employee Safety Events

- An employee gets blood in their eye when emptying a drain and not wearing eye protection
- An employee is threatened by a patient while registering them for their appointment
- An employee is exposed to a chemical or radiation while cleaning a room
- An office worker has concerns about their ergonomics in their workspace and complaints of a sore back and wrist
- An employee injures their back while assisting a patient to a chair

What Can Be Learned From An Undercover CNO

- Workflows are Challenging
- Giving Medication is Harder Than It Should Be
- Equipment Matters
- End of Shift Report Takes Too Long

EMERGINGRNLEADER
DEDICATED TO DEVELOPING THE LEADER IN YOU

A CNO Goes Incognito – An Update

April 22, 2024 by rose

By Rose O. Sherman, EdD, RN, NEA-BC, FAAN

I published the blog below two years ago as we emerged from the COVID-19 pandemic. At the time, many leaders were fascinated with this blog and asked about the CNO's identity. I promised confidentiality to the CNO at the time. We even changed the identity from male to female to avoid detection. Fast-forward to today, and Brian Weirich, a Nurse Executive with Banner Health, has openly acknowledged that he was the CNO who went undercover. In an upcoming don't-miss interview hosted by Becker's Hospital Review (Wednesday, April 24th, 1 PM to 2 PM CST), Brian and I discuss his experience and how he uses what he learned as a travel nurse in his executive leadership role. To register for this free program, use this link.

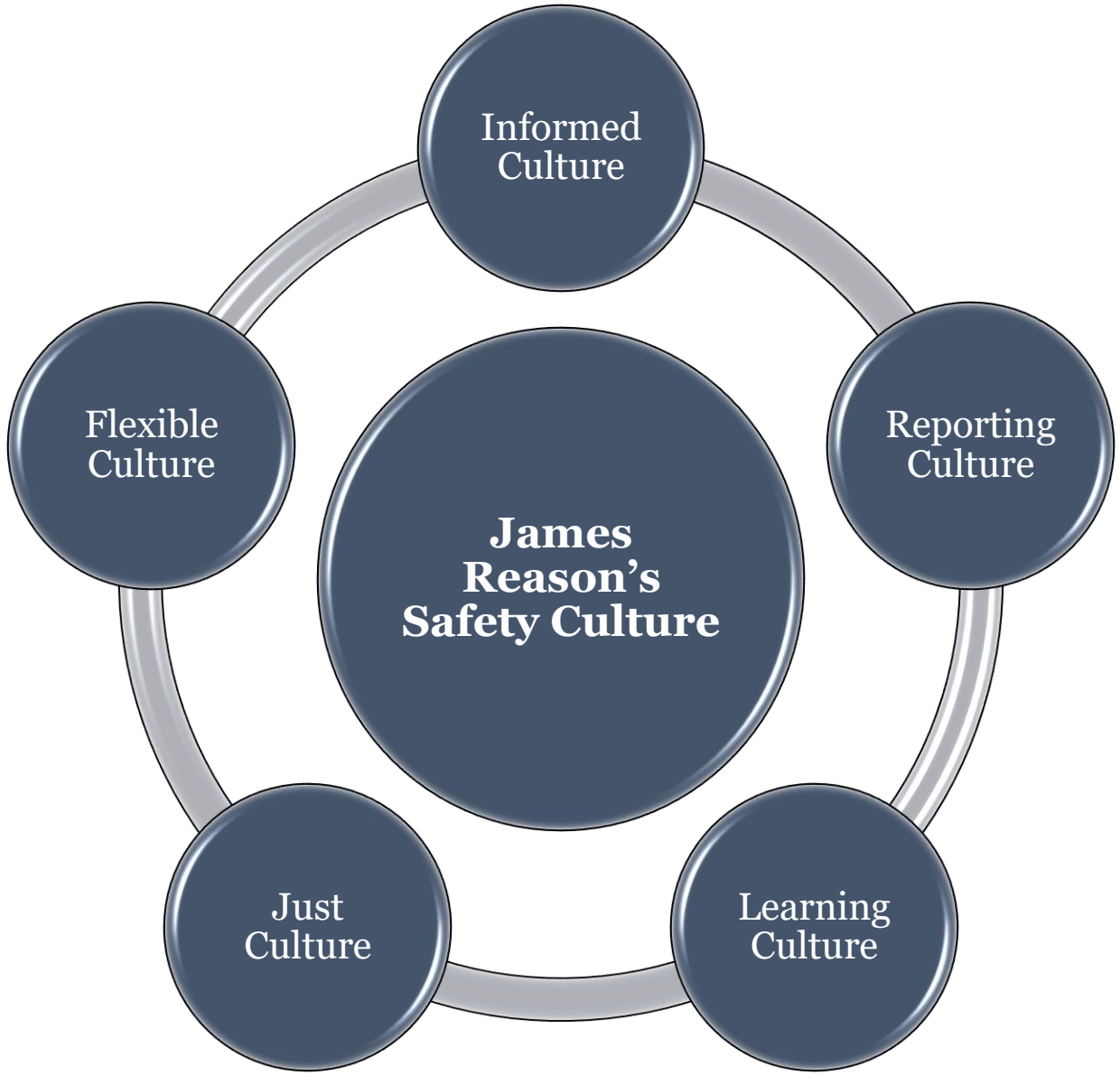
The Blog First Published on November 22nd, 2022

You may be familiar with the television show *Undercover Boss*, where CEOs and business owners go undercover in their businesses, working at the point of service for an extended period to assess what is happening with people and processes. Their discoveries are often quite revealing. Some Chief Nursing Officers also schedule monthly or quarterly clinical days to stay in touch with staff nurses. While this visibility is excellent, unit leaders often heavily

Free Resource!!! **Sign up for Blog :** Emerging Nurse Leader - A leadership development blog (emergingrnleader.com)

What Can We Do To Redesign Our System to Improve Outcomes?

Cultivate a Culture of Safety



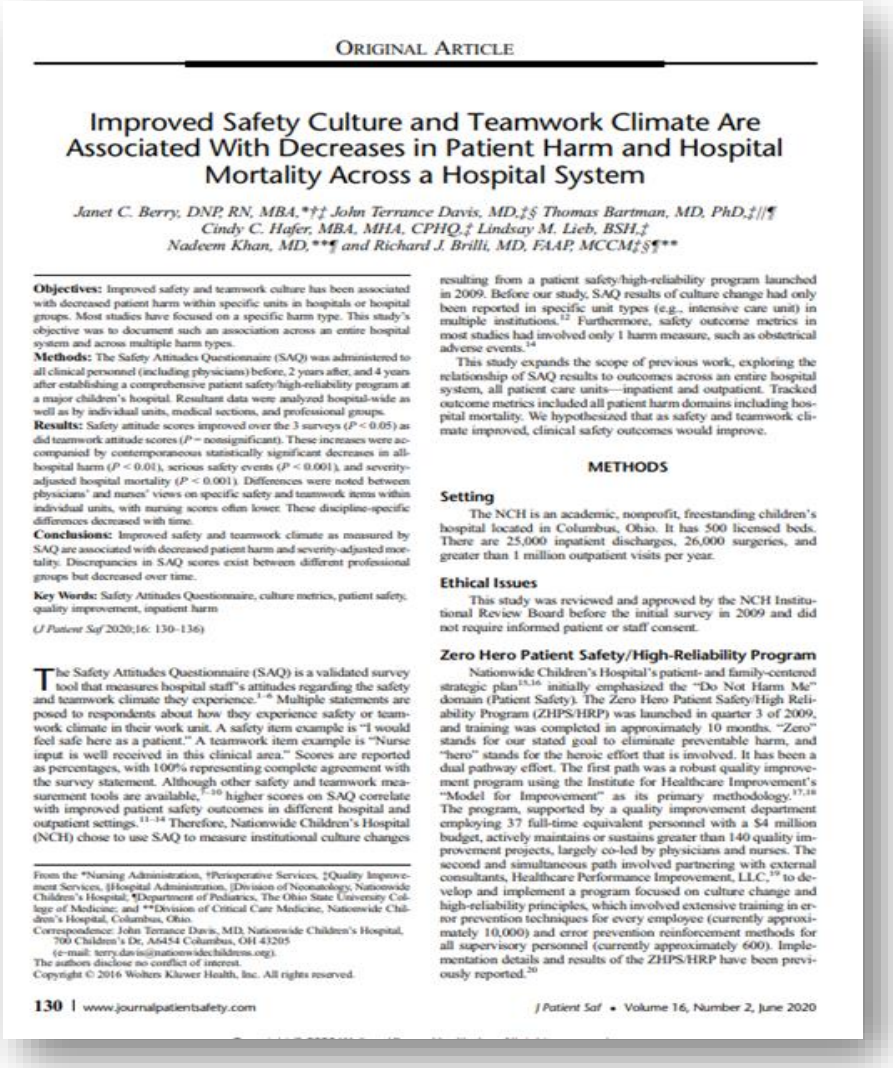
Literature Review

- **Patient Safety Programs Are Needed, But Progress is Slow**
  - Develop a **culture of safety** and improve health care outcomes (Kohn et al., 2000)
  - Positive correlation between a hospital's **patient safety culture** and patient care outcomes (DiCuccio,2015)
  - Organizations are struggling to implement and maintain robust patient safety programs that result in improved patient safety outcomes
    - 9% of surveyed hospitals indicating no written patient safety plan and only 74% with a fully implemented plan (Longo et al., 2005)
  - Additional research is needed to identify effective strategies for improving a culture of safety

- **Leadership Engagement is Critical**
  - Consistent and authentic engagement by leadership results in significant progress in patient safety (Moffatt-Bruce et al., 2018)
  - It is critical to engage leaders in the prioritization efforts of patient safety work (Campione and Famolaro, 2018)

Literature Review

- Improved Safety Culture Linked with…
  - Decrease in Serious Safety Event Rate
  - Improved Mortality
  - Additional research is needed to identify effective strategies for improving a culture of safety



ORIGINAL ARTICLE

Improved Safety Culture and Teamwork Climate Are Associated With Decreases in Patient Harm and Hospital Mortality Across a Hospital System

Janet C. Berry, DNP, RN, MBA,†‡ John Terrance Davis, MD,‡§ Thomas Bartman, MD, PhD,‡∥¶ Cindy C. Hafer, MBA, MHA, CPHQ,‡ Lindsay M. Lieb, BSH,‡ Nadeem Khan, MD,**¶ and Richard J. Brilli, MD, FAAP, MCCM‡§¶***

Objectives: Improved safety and teamwork culture has been associated with decreased patient harm within specific units in hospitals or hospital groups. Most studies have focused on a specific harm type. This study's objective was to document such an association across an entire hospital system and across multiple harm types.

Methods: The Safety Attitudes Questionnaire (SAQ) was administered to all clinical personnel (including physicians) before, 2 years after, and 4 years after establishing a comprehensive patient safety/high-reliability program at a major children's hospital. Resultant data were analyzed hospital-wide as well as by individual units, medical sections, and professional groups.

Results: Safety attitude scores improved over the 3 surveys ($P < 0.05$) as did teamwork attitude scores (P = nonsignificant). These increases were accompanied by contemporaneous statistically significant decreases in all-hospital harm ($P < 0.01$), serious safety events ($P < 0.001$), and severity-adjusted hospital mortality ($P < 0.001$). Differences were noted between physicians' and nurses' views on specific safety and teamwork items within individual units, with nursing scores often lower. These discipline-specific differences decreased with time.

Conclusions: Improved safety and teamwork climate as measured by SAQ are associated with decreased patient harm and severity-adjusted mortality. Discrepancies in SAQ scores exist between different professional groups but decreased over time.

Key Words: Safety Attitudes Questionnaire, culture metrics, patient safety, quality improvement, inpatient harm

(*J Patient Saf* 2020;16: 130–136)

The Safety Attitudes Questionnaire (SAQ) is a validated survey tool that measures hospital staff's attitudes regarding the safety and teamwork climate they experience.[1–9] Multiple statements are posed to respondents about how they experience safety or teamwork climate in their work unit. A safety item example is "I would feel safe here as a patient." A teamwork item example is "Nurse input is well received in this clinical area." Scores are reported as percentages, with 100% representing complete agreement with the survey statement. Although other safety and teamwork measurement tools are available,[7–10] higher scores on SAQ correlate with improved patient safety outcomes in different hospital and outpatient settings.[11–14] Therefore, Nationwide Children's Hospital (NCH) chose to use SAQ to measure institutional culture changes resulting from a patient safety/high-reliability program launched in 2009. Before our study, SAQ results of culture change had only been reported in specific unit types (e.g., intensive care unit) in multiple institutions.[12] Furthermore, safety outcome metrics in most studies had involved only 1 harm measure, such as obstetrical adverse events.[14]

This study expands the scope of previous work, exploring the relationship of SAQ results to outcomes across an entire hospital system, all patient care units—inpatient and outpatient. Tracked outcome metrics included all patient harm domains including hospital mortality. We hypothesized that as safety and teamwork climate improved, clinical safety outcomes would improve.

METHODS

Setting

The NCH is an academic, nonprofit, freestanding children's hospital located in Columbus, Ohio. It has 500 licensed beds. There are 25,000 inpatient discharges, 26,000 surgeries, and greater than 1 million outpatient visits per year.

Ethical Issues

This study was reviewed and approved by the NCH Institutional Review Board before the initial survey in 2009 and did not require informed patient or staff consent.

Zero Hero Patient Safety/High-Reliability Program

Nationwide Children's Hospital's patient- and family-centered strategic plan[15,16] initially emphasized the "Do Not Harm Me" domain (Patient Safety). The Zero Hero Patient Safety/High Reliability Program (ZHPS/HRP) was launched in quarter 3 of 2009, and training was completed in approximately 10 months. "Zero" stands for our stated goal to eliminate preventable harm, and "hero" stands for the heroic effort that is involved. It has been a dual pathway effort. The first path was a robust quality improvement program using the Institute for Healthcare Improvement's "Model for Improvement" as its primary methodology.[17,18] The program, supported by a quality improvement department employing 37 full-time equivalent personnel with a $4 million budget, actively maintains or sustains greater than 140 quality improvement projects, largely co-led by physicians and nurses. The second and simultaneous path involved partnering with external consultants, Healthcare Performance Improvement, LLC,[19] to develop and implement a program focused on culture change and high-reliability principles, which involved extensive training in error prevention techniques for every employee (currently approximately 10,000) and error prevention reinforcement methods for all supervisory personnel (currently approximately 600). Implementation details and results of the ZHPS/HRP have been previously reported.[20]

From the *Nursing Administration, †Perioperative Services, ‡Quality Improvement Services, §Hospital Administration, ∥Division of Neonatology, Nationwide Children's Hospital; ¶Department of Pediatrics, The Ohio State University College of Medicine; and **Division of Critical Care Medicine, Nationwide Children's Hospital, Columbus, Ohio.

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The authors disclose no conflict of interest.

Components of a Safety Culture

Informed Culture

- Patient Safety Indicators
- Workforce Safety Indicators
- Culture of Safety Survey Scores
- Tiered Huddles
- Department Visual Management Boards

Reporting Culture

- Good Catch Program
- Psychological Safety
- Venues Exist for Sharing What is Not Going Well

Just Culture

- Hard on the Process, Not on the People
- The Health System is Accountable for the System That Has Been Designed
- Employees are accountable for their choices – humans are fallible and will not achieve perfection

Learning Culture

- Learning & improving from events (RCA, ACA, FMEA)
- Sharing lessons learned
- Learning from others – industry surveillance (ISMP, ECRI)

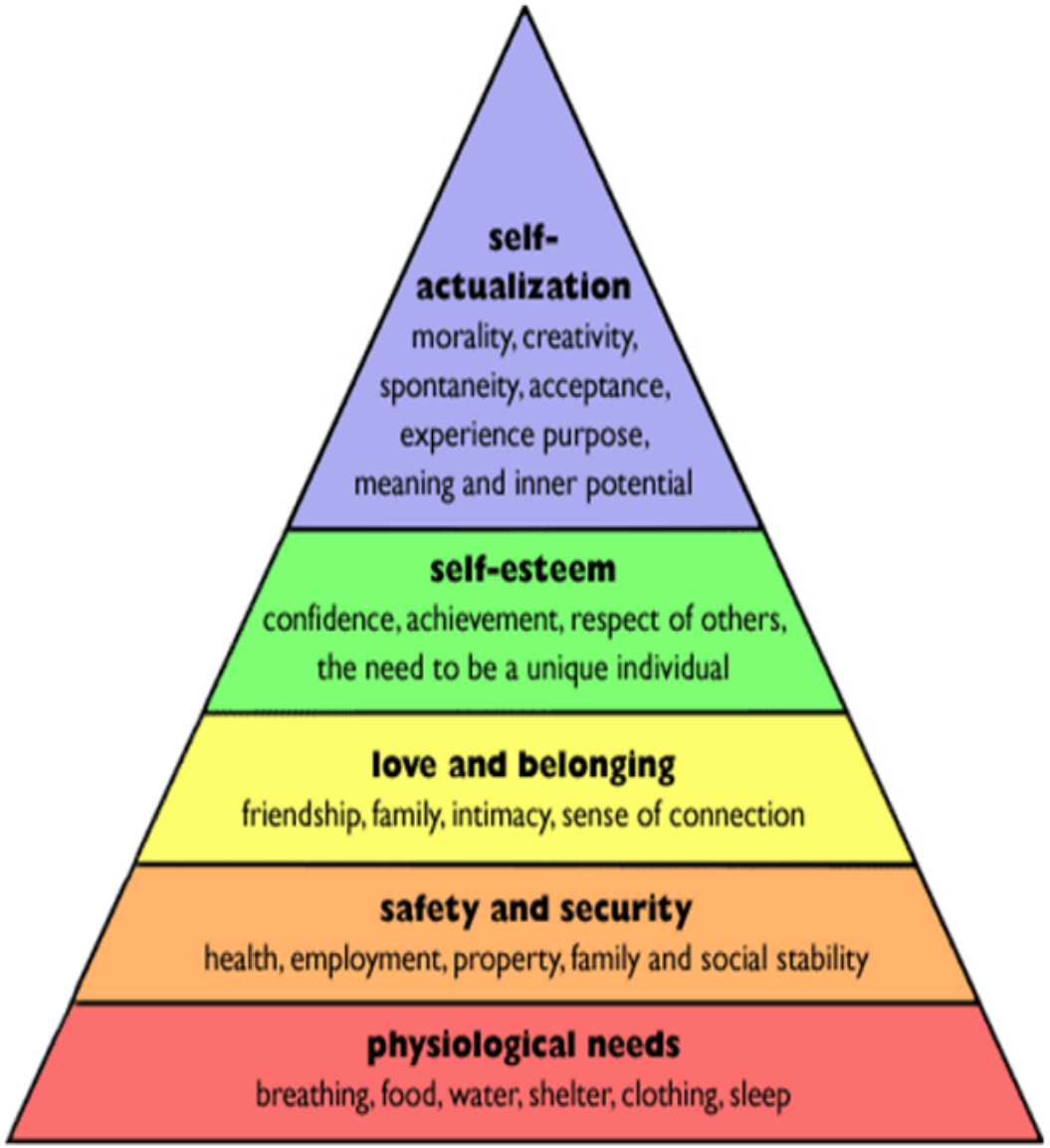
Flexible Culture

- Joy in the Workplace
- Recognition
- HOPE Program (2nd Victim)
- Resiliency
- Teamwork

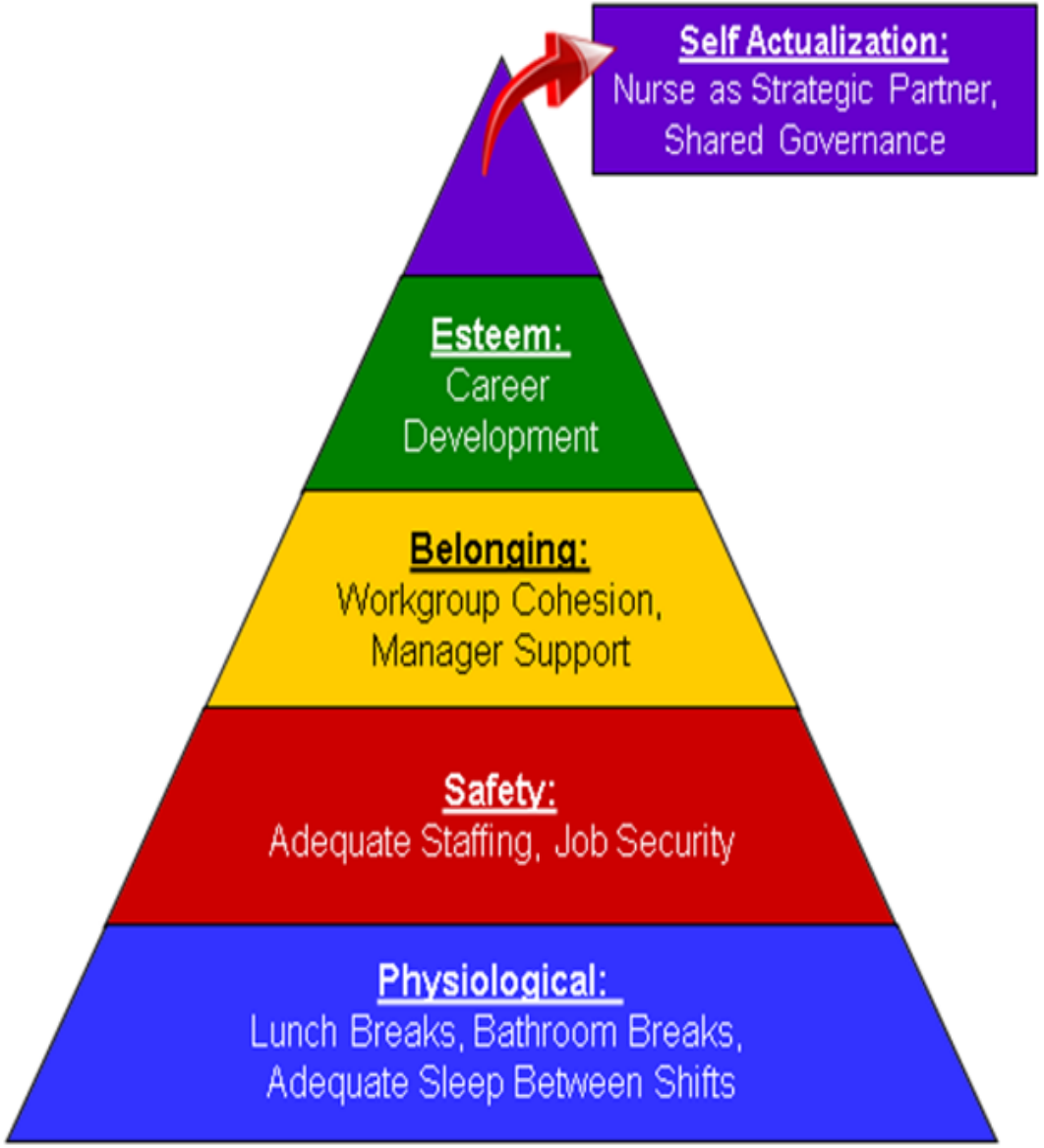
Leadership Commitment

- Commit to Zero Harm for Patients & Employees
- HRO Principles
- Psychological Safety
- Leadership Walk Rounds

Safety & Patient Experience



Maslow's Hierarchy of Needs

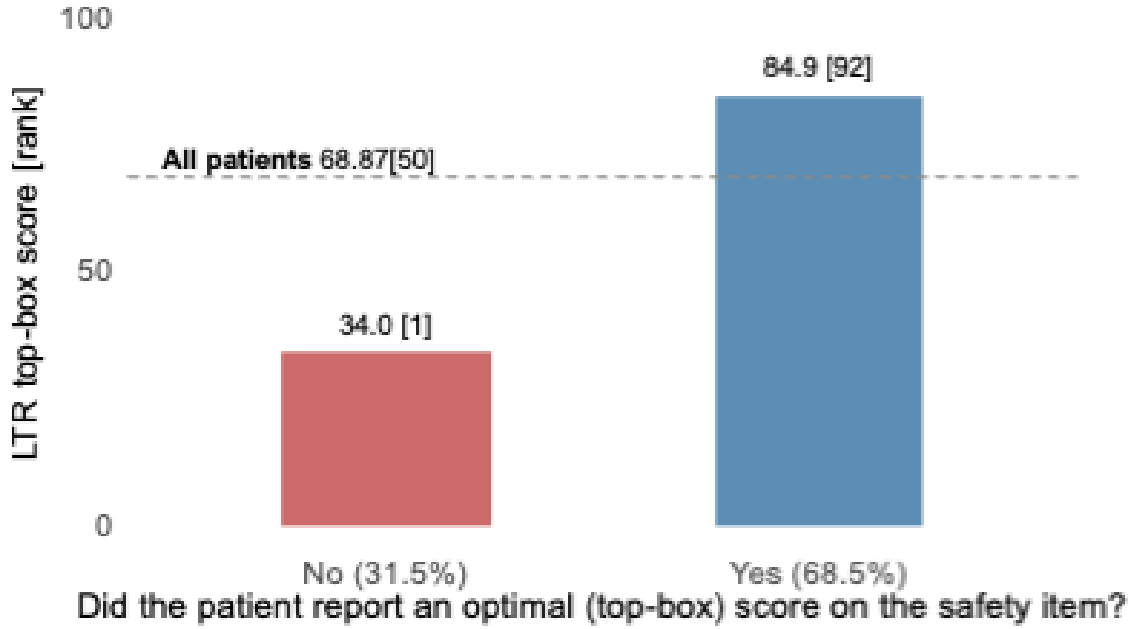


A Nurse's Hierarchy of Needs by Karen Cox, RN, PhD

Engagement & Safety Drive Performance

- **Reference:** [Prioritizing safety as the foundation for staff engagement and retention in healthcare (pressganey.com)]

Inpatient Experience of Safety & Likelihood to Recommend



- Of patients who **report optimal experiences of safety**, 84.9% would "Definitely Recommend" the hospital.
- Of patients who **do not report optimal experiences of safety**, only 34% would "Definitely Recommend" the hospital.

- Inpatient HCAHPS & Integrated surveys received from June 2022 – May 2023.
- n = 195,442
- Respondents must have answered both safety and LTR items.

- **Reference:** [Prioritizing safety as the foundation for staff engagement and retention in healthcare (pressganey.com)]

What is Safe?

Patient & Family Point of View

- A visually clean environment
- Introductions & eye contact
- Engage me in my care, validate why I am here, manage my expectations
- Talk up the care team, “I’ve worked with so-and-so for years, they are a great [doctor, nurse, surgeon, tech]
- Act like you have time for me
- Sit with me, not over me
- If you don’t know…it is okay, circle back

What is Safe?

Employee Point of View

- A safe environment – protect me from the hazards of healthcare, make it safe for me to speak up
- Introductions & eye contact – get to know me
- Engage me in my professional development, validate why I am here, manage my expectations
- Act like you have time for me, be present
- Connect my work with a sense of purpose – link to the organization's goals
- If I report something, show me what is being done about it
- If you don't know…it is okay, circle back

Psychologically Safe Employees are Engaged Employees

Emotional Connection

Emotional connection among people creates the conditions and motivation to do great work and navigate adversity together; in many cases a group that achieves this state is strengthened by adversity.

Trusting Relationship

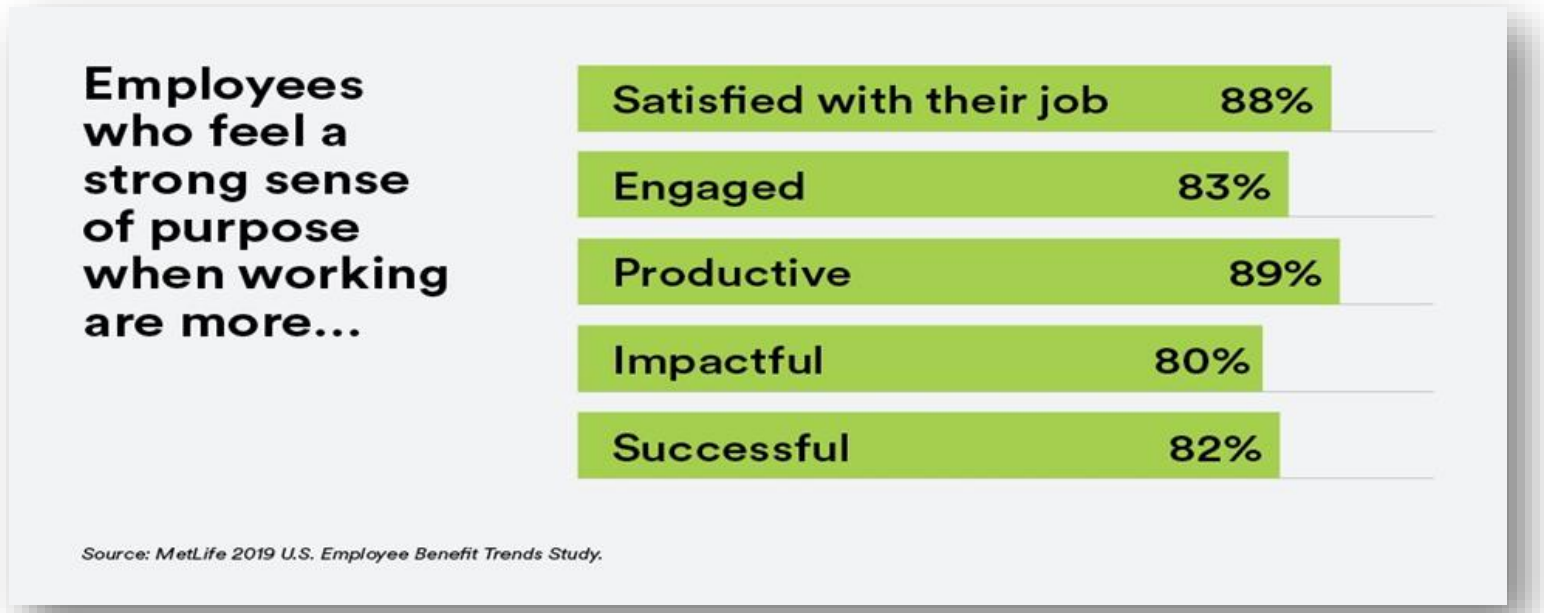
Over time, the practice of Psychological Safety builds trust and Emotional Capital among those leading the change and the people impacted by it.

Interpersonal Risk-Taking

Starting with those leading the change, a culture can be developed to encourage ideas and concerns to be voiced without fear of negative consequences. This influences the experience of those impacted by the change.

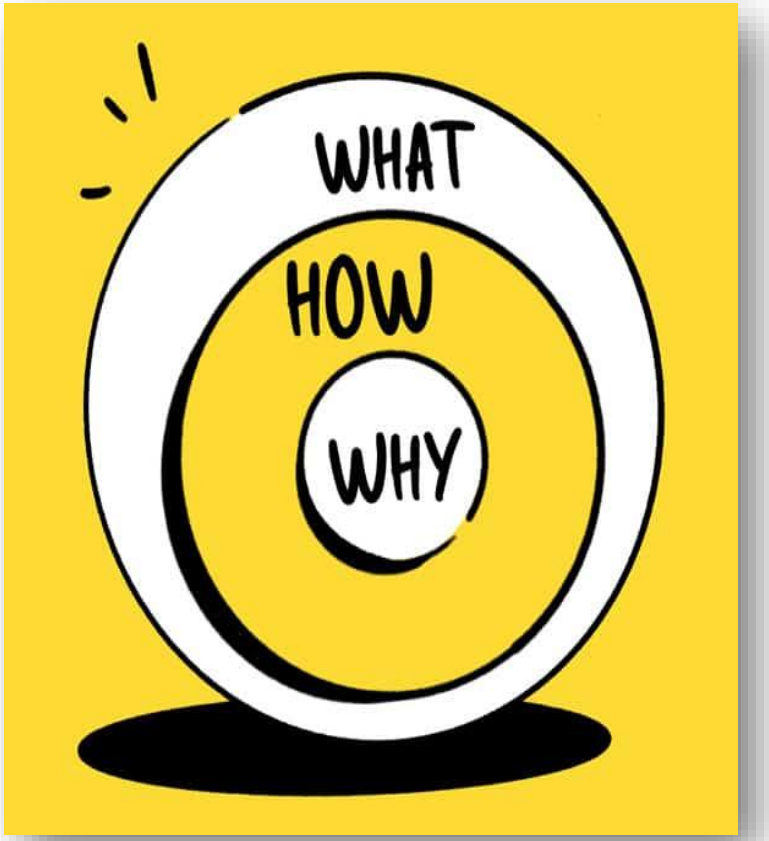
The Importance of Purpose & Belonging

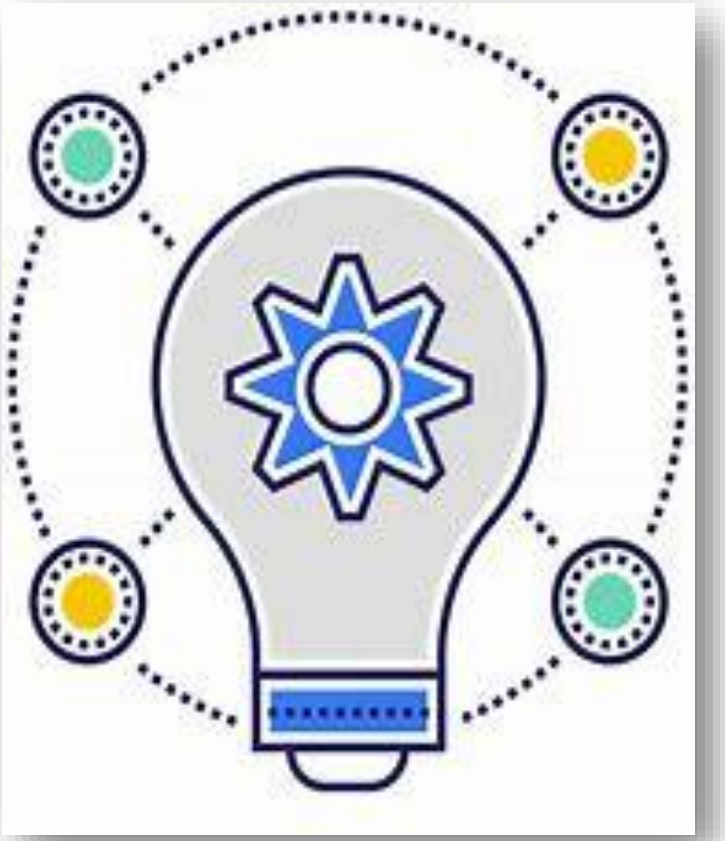
- How often are you vigorously conveying the compelling rationale for why you and your team do what they do?
- Emphasizing a Sense of Purpose
- Telling people WHY What They Do Matters!
- Feeling purpose and meaning is a primal need



Practical Tools & Tips for Safety Leaders

All Teach, All Learn





Share your convictions on patient or personal safety

Explain how safety contributes to the organization's mission

Tell a story about safety or harm occurring in the organization – share lessons learned

Tell a story about safety or harm occurring in another organization – learn from others

Share a concern that keeps you up at night

Review a high reliability principle and discuss how it relates to work or outside of work

Explain how policy, procedure, or expectations contribute to safety

Discuss the important of reporting events

Thank staff for their commitment to safety

Tip #1:
Start Every Meeting with a Safety Message

TOTAL	23 Patient Events, 20 Employee Assaults 4/11 – 4/17	
Event Type	**# Patients Impacted**	**Additional Details**
Patient Identification Events	19 Reported Events **Additional details available upon request*	Events: Specimen Labeling (7), ECG (3), Charting Error (2), Medication (2), Registration (2), Wristband (2), Communication of PHI (1) **FY2024 (YTD-MAR) – 900 Patient Identification Events**
Transfusion of the Wrong Product or to the Wrong Patient	0 Reported Events	**FY2024 (YTD-MAR) – 1 Transfusion Events**
Medication Events Resulting in Preventable Harm	0 Reported Events Resulting in Preventable Harm	**FY2024 (YTD-MAR) – 16 Medication Events**
CAUTI	0 Confirmed	**FY2021 – 50 CAUTI** **FY 2022 – 52 CAUTI** **FY 2023 – 41 CAUTI** **FY2024 (YTD-MAR) – 25 CAUTI**
CLABSI	3 Confirmed CA5 ICU HC9 ICU HC9 ICU **Note: 10 CLABSI confirmed for March. Opportunities with in-room hand hygiene, dressing changes, and culturing stewardship practices*	**FY2021 – 50 CLABSI** **FY 2022 – 71 CLABSI** **FY 2023 – 52 CLABSI** **FY2024 (YTD-MAR) – 53 CLABSI**
CDIFF	1 Confirmed CA5 ICU	**FY2021 – 151 CDI** **FY 2022 – 172 CDI** **FY 2023 – 196 CDI** **FY 2024 (YTD-MAR) – 24 CDI**
HAPI	0 Patients with Stage 3, 4, or Unstageable HAPI	**FY2021 – 109 HAPI Stage 3, 4, and Unstageable** **FY 2022 – 107 HAPI Stage 3, 4, and Unstageable** **FY 2023 – 71 HAPI Stage 3, 4, and Unstageable** **FY2024 (YTD-MAR) – 44 HAPI Stage 3, 4, and Unstageable**
Falls with Moderate or Major Injury	0 Moderate/Major Injury Fall	**FY 2021 – 28 Falls with Moderate/Major Injury** **FY 2022 – 23 Falls with Moderate/Major Injury** **FY2023 – 41 Falls with Moderate/Major Injury** **FY2024 (YTD-MAR) – 15 Falls with Moderate/Major Injury**
Employee Assaults	20 Reported Assaults • 18 No Injury • 2 Minor Injury	**FY2024 (YTD-MAR) – 505 Employee Assaults by Patients** **Note: Data reconciled for consistency in definitions, resulted in increase in reported assaults as verbal, sexual, and physical are now all included*

- Informed/Reporting Culture
- Commitment to Zero
- Consistency: Daily, Weekly, Monthly
- Everyone Knows What We Are Working Toward

Tip #2 –

Make Your Performance Visible

Tip #3
Establish Department Level Check Ins

Recent Safety Events	HAC concerns	1:1 patients
High risk medications	Equipment issues	Name alerts
Patients in Isolation	Staffing issues	Other concerns

Clinical Department Example

Safety Message	What is your priority work today?
How can the team help?	How can I help?
Team Shoutouts!	Who is out of office today?

Support Department Example

Event Date	Title	Event Type	Event Response	Status	Contact	Provide an Updat
12/28/2023	Newborn Patient ID	Safety Team Consu	Failure Mode & Effects Analysis	Open	Debbie Pennington Corinne Reynolds	05/10/2024
01/09/2024	EP Lab Patient ID Workflow Gemba	Safety Team Consu	No Further Action	Quality Team Assic	Samantha Wenger Julia Myers	
01/15/2024	BH 65 ICU - Corpak Placed in Lungs	SI, Risk Notificatio	Additional Investigation Needed	Closed	Amanda Cackler Debbie Pennington Connie Chappelle Kacie Heid	
01/15/2024	Suicidal Patient at Marillac, Multiple Attempts (Sock, U...	SI, Risk Notificatio	Defer to Local Leadership	Closed	Heidi Boehm	
01/17/2024	Expired Blood Collection Tubes	PSRT	New Performance Improvement Team	Quality Team Assic	Amanda Cackler Angie Bruns	05/17/2024
01/18/2024	Understand Current State of Narcotic Lockboxes	Safety Team Consu	Additional Investigation Needed	Closed	Amanda Cackler Troy Butcher	
01/18/2024	Code Cart Stocking - Health System	Safety Team Consu	Additional Investigation Needed	Open	Amanda Cackler Whitney Hessel Sheri Killer	05/03/2024
01/19/2024	Voluntary Recall - Atropine, Sodium Bicarbonate	PSRT		No Further Action		
01/19/2024	Isotope Administration - Wrong Patient	PSRT	Defer to Local Leadership	No Further Action	Rick Couldry	
01/23/2024	Indian Creek - Care of Declining Patient	SI, Risk Notificatio	Root Cause Analysis & Action	Quality Team Follo	Christina Grey Debbie Pennington Beth Eide Trang Luu	05/10/2024
01/31/2024	Override on Bag-Valve Mask	PSRT	No Further Action	Closed	Liz Carlton Gale Carpenter	
02/02/2024	Medication Storage Standards	Medication Safety	Additional Investigation Needed		Whitney Hessel	05/03/2024
02/05/2024	ACT Machines (IR/CV Labs)	PSRT	Defer to Local Leadership	Open	Beth Eide Amber Styles Melinda Loy	05/10/2024

Weekly Huddle - Who Is Working On What?

Quality, Safety, Risk, Claims

Tip #4 – Go & See

Informed Culture

Trust, but Verify

Is what we think is happening, what is happening?

Leadership Walk Rounds

What is going well?

What could be going better?

DOI: 10.1111/j.1475-6773.2006.00572.x

Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability

Allan S. Frankel, Michael W. Leonard, and Charles R. Denham

Background. Disparate health care provider attitudes about autonomy, teamwork, and administrative operations have added to the complexity of health care delivery and are a central factor in medicine's unacceptably high rate of errors. Other industries have improved their reliability by applying innovative concepts to interpersonal relationships and administrative hierarchical structures (Chandler 1962). In the last 10 years the science of patient safety has become more sophisticated, with practical concepts identified and tested to improve the safety and reliability of care.

Objective. Three initiatives stand out as worthy regarding interpersonal relationships and the application of provider concerns to shape operational change: The development and implementation of Fair and Just Culture principles, the broad use of Teamwork Training and Communication, and tools like WalkRounds that promote the alignment of leadership and frontline provider perspectives through effective use of adverse event data and provider comments.

Methods. Fair and Just Culture, Teamwork Training, and WalkRounds are described, and implementation examples provided. The argument is made that they must be systematically and consistently implemented in an integrated fashion.

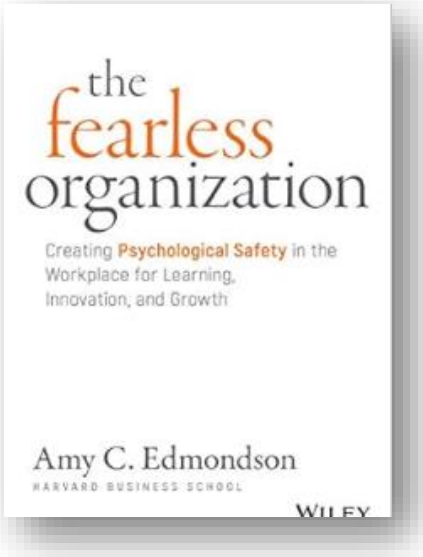
Conclusions. There are excellent examples of institutions applying Just Culture principles, Teamwork Training, and Leadership WalkRounds—but to date, they have not been comprehensively instituted in health care organizations in a cohesive and interdependent manner. To achieve reliability, organizations need to begin thinking about the relationship between these efforts and linking them conceptually.

Key Words. Safety, teamwork, leadership, walkrounds, reliability, culture

"In an era when no individual can know or do everything needed to carry out the work that serves customers, it's more important than ever for people to speak up, share information, contribute expertise, take risks, and work with each other to create lasting value."

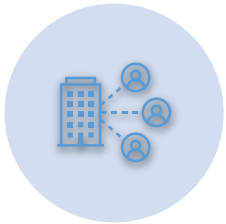
"Employee observations, questions, ideas, and concerns can provide vital information about what is going on in an organization."

"Today's leaders must be willing to take on the job of driving fear out of the organization to create conditions for learning, innovation, and growth."



Tip #5 – Cultivate Psychological Safety

Psychological Safety:
A Vital Leadership Responsibility



ASK THE PEOPLE WHO DO THE WORK HOW IT CAN BE DONE BETTER

DON'T FIX, JUST LISTEN

PROMOTE HEALTHY DISAGREEMENT, VIGOROUS DEBATE, EVEN

SHOW APPRECIATION & GIVE CREDIT TO OTHERS FOR THEIR WORK

UNDERSTAND PERSONAL PREFERENCES ON RECOGNITION AND MOTIVATION

BE TRANSPARENT & AUTHENTIC IN WORDS & ACTION

The Leader's Tool Kit

Patient Safety at Children's Minnesota

- **Setting the Stage**
  - ✓ Healthcare is a complex system, prone to breakdowns
  - ✓ Urgency to achieve the goal of 100% safe care

- **Inviting Participation**
  - ✓ Was everything as safe as you would like it to have been **this week** with **your patients**?
  - ✓ Genuine. Curious. Direct.
  - ✓ Structures: Patient safety steering committee (PSSC), Blameless Reporting, Focus Groups

- **Responding Productively**
  - ✓ Speaking up is only the first step
  - ✓ Response must be appreciative, respectful, and offer a path forward
  - ✓ Use of the focused event analysis (FEA)

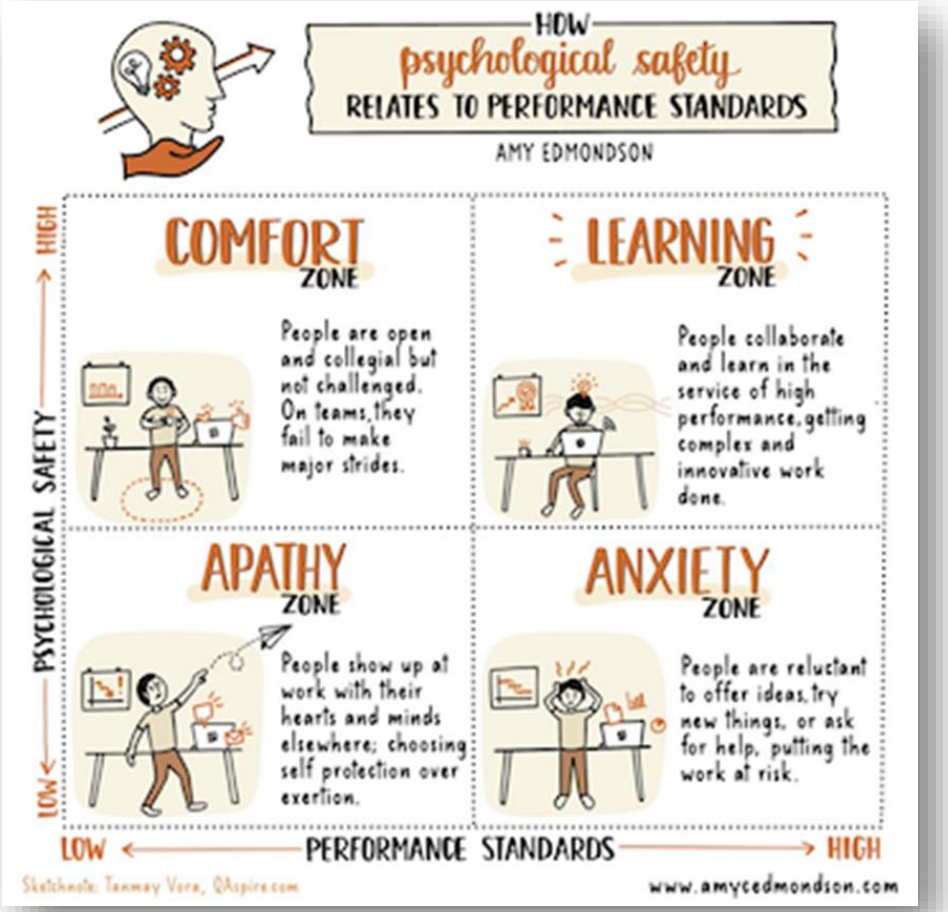
Category	Setting the Stage	Inviting Participation	Responding Productively
Leadership tasks	**Frame the Work** • Set expectations about failure, uncertainty and interdependence **Emphasis Purpose** • Identify what's at stake, why it matters, and for whom	**Demonstrate Situational Humility** • Acknowledge gaps **Practice Inquiry** • Ask good questions • Model intense listening **Set up Structures and Processes** • Create forums for input • Provide guidelines for discussion	**Express Appreciation** • Listen • Acknowledge and thank **Destigmatize Failure** • Look forward • Offer help • Discuss, consider and brainstorm next steps **Sanction Clean Violations**
Accomplishes	Shared expectations and meaning	Confidence that voice is welcome	Orientation towards continuous learning

The Leader's Tool Kit for Building Psychological Safety

Patient Safety at Children's Minnesota

What Psychological Safety Is Not

- **It is not about being nice** – it's quite the opposite, it is about candor, productive disagreement and free exchange of ideas, speaking candidly on different sides of a conflict.
- **It is not a personality factor** – not linked with extroversion or introversion
- **It is not about lowering performance standards**
- **It is not just another word for trust** – it is experienced at a group level, where trust is typically individualized



Tip #6:
Make it Safe to Fail

- Fail forward
  - What can we learn?
  - What can we change?
  - What workarounds can we remove?

- Preventing avoidable failure starts with encouraging people to push back, share data, actively report on what is really happening, creating a continuous loop of learning and agile execution

Avoiding Avoidable Failure

Countless small problems routinely occur, presenting early warning signs that a organization's strategy may be falling short and needs to be revisited

Productive Responses to Failure

Preventable	Complex	Intelligent
• Training • Retraining • Process Improvement • System Redesign • Sanctions, if repeated or otherwise blameworthy actions are found	• Failure analysis from diverse perspectives • Identification of risk factors to address • System Improvement	• Failure parties • Failure awards • Thoughtful analysis of results • Brainstorming of new hypotheses • Design of next steps or additional experiments


Management is doing things right; leadership is doing the right things.
Peter F. Drucker
quotefancy

Element of Safety Culture	Patient Safety Risk, Quality Outcome Measure, Risk Prevention Strategy (a)	Current Performance (b)	Impact on Error Reduction (c)	Required Measure (d)	Risk to Organization, Patient, or Healthcare Workers if Incomplete (e)	Risk Prioritization Number (RPN)
- Informed - Reporting - Learning - Just - Flexible		5 – Unknown, Not Measured, Significantly Underperforming Goal 4 – Underperforming Goal 3 – Meeting Goal 2 – Outperforming Goal 1 – Significantly Outperforming Goal	3 – High Yield 2 – Medium Yield 1 – Low Yield	2 – Yes 1 – No	4 – Severe 3 – Moderate 2 – Mild 1 – Minimal/None	Calculated by multiplying the values identified for each criterion RPN = a X b X c X d X e

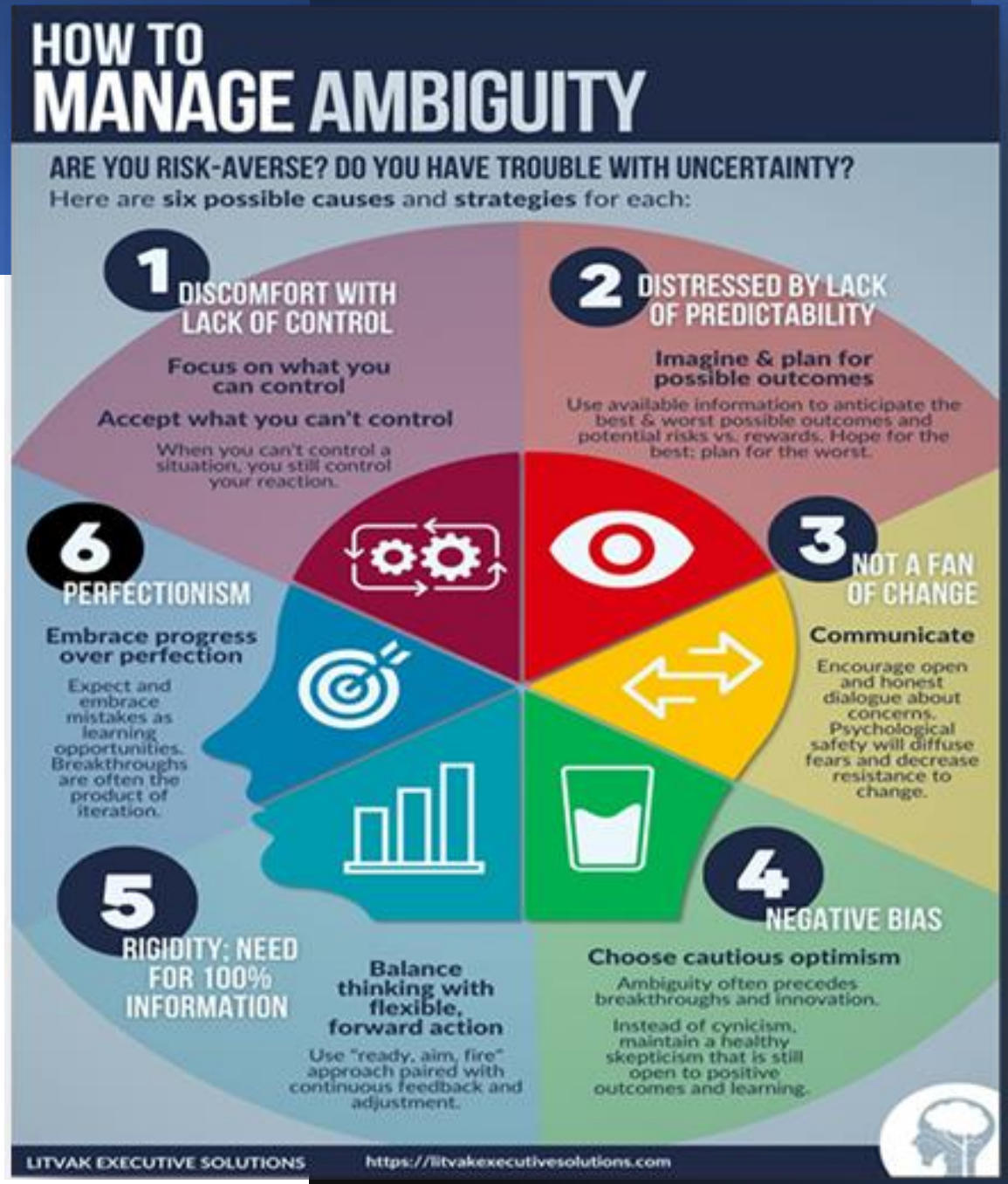
- There is no single, universal measure for safe, high-quality patient care
- There are countless quality and safety measures for healthcare leaders to consider
- Focusing only on mandated measures does not result in healthcare delivery that is free from harm
- Risk assessments can identify the greatest threats to patient safety as an effective way to prioritize limited resources

Tip #7 – Use Risk Assessments for Everything

Tip #8 – Learn How to Manage Ambiguity

My Journey…

1. I can control how I share new information with the team
2. What is the worst-case scenario?
3. I can invite open dialogue with the team
   - You Can Be Curious, Ask All the Questions
   - I will not always have the answers
4. This journey will better prepare us for the next hospital that enters our System
5. Continuous Feedback & Flexibility
   - Team Distribution Changes
6. This will not be perfect, but it will be better



Tip #9 – Give Trust, Develop Trust

Delegation is a Sign of Trust

- An opportunity for someone else to learn, to show up, or develop a new skill
- Trust, but Verify
- Be Clear – Clear is Kind, What Does Done Look Like?

You Will Make Mistakes

- Admit mistakes, own them
- Highlight your learning action plan

Ask for Feedback

- Put your ego aside and unwrap the gift of feedback
- Develop the art of self-reflection

Commit to What You Say You Will Do

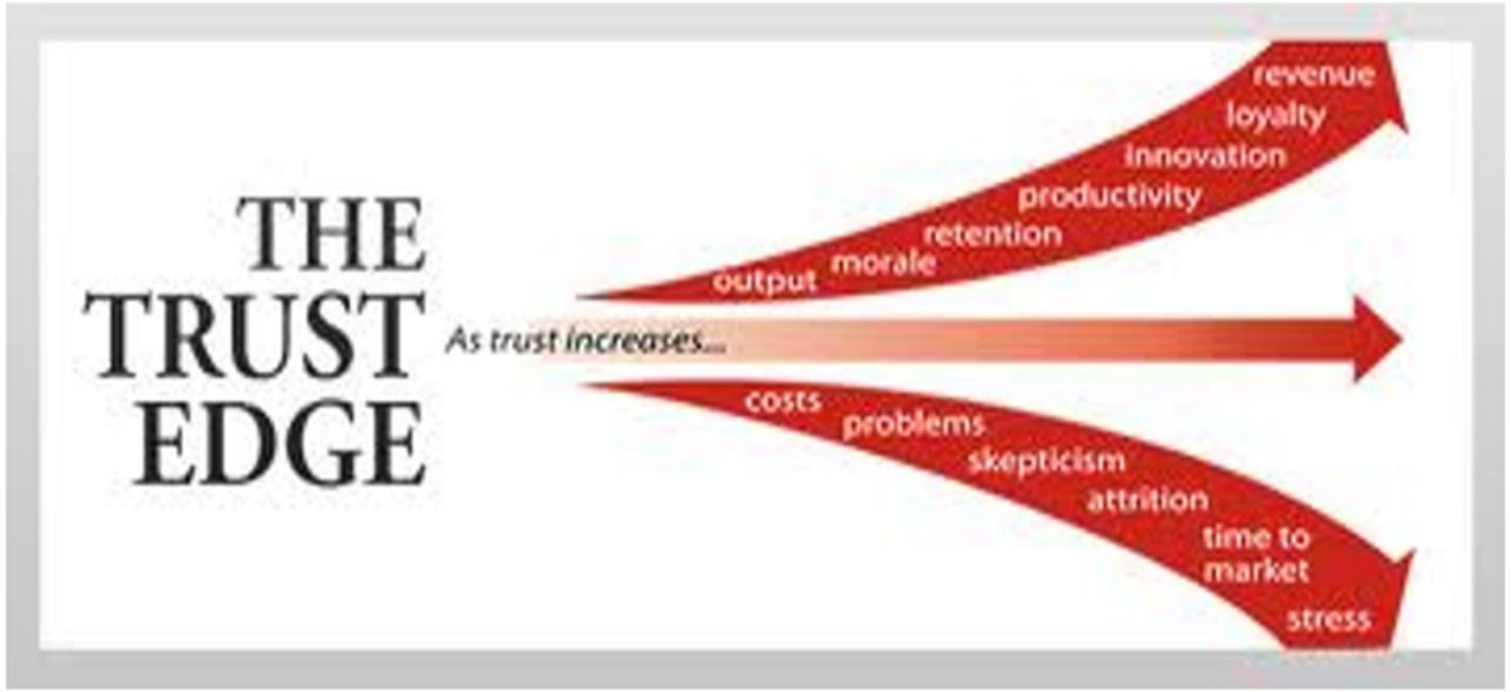
- Consistency
- Reliability
- Credibility
- Influence

Be Present

- Listen
- Prepare - what is distracting you now – shut it off and focus on the person
- Virtual? Show your hands, make eye contact
- Clarify – do you want to vent or do you want me to do something?

Develop Those Around You

- Give back to those you lead
- Help them to become the best versions of themselves – not becoming more like you
- Help those who are doing poorly to do better and those who are doing well to do great



The Trust Edge, David Horsager

CLARITY
People trust the clear and mistrust the ambiguous.

COMPASSION
People put faith in those who care beyond themselves.

CHARACTER
People notice those who do what is right over what is easy.

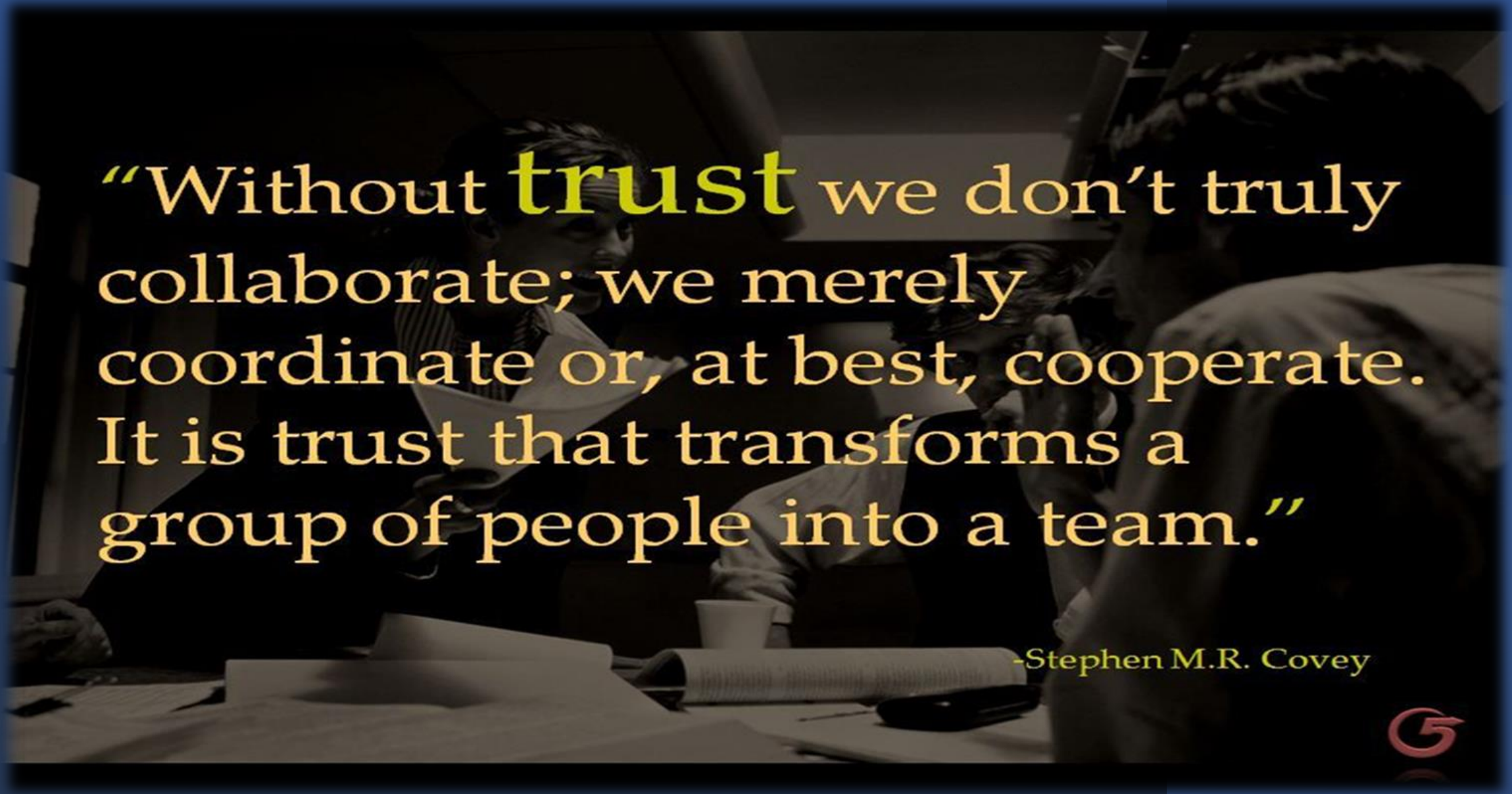
COMPETENCY
People have confidence in those who stay fresh, relevant, & capable.

COMMITMENT
People believe in those who stand through adversity.

CONNECTION
People want to follow, buy from and be around friends.

CONTRIBUTION
People immediately respond to results.

CONSISTENCY
People love to see the little things done consistently.


"Without trust we don't truly collaborate; we merely coordinate or, at best, cooperate. It is trust that transforms a group of people into a team."
-Stephen M.R. Covey

You cannot be an expert in every field you manage. Surround yourself with subject matter experts in their discipline

Form a team of experts, with diverse backgrounds, perspectives, & experiences

Tip #10 – Surround Yourself With People Who Are Smarter Than You

Thank You For Your Time!

QUESTIONS?

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