Senior Leaders' Roles and Responsibilities

North Carolina Center for Hospital Quality and Patient Safety
Leadership Conference
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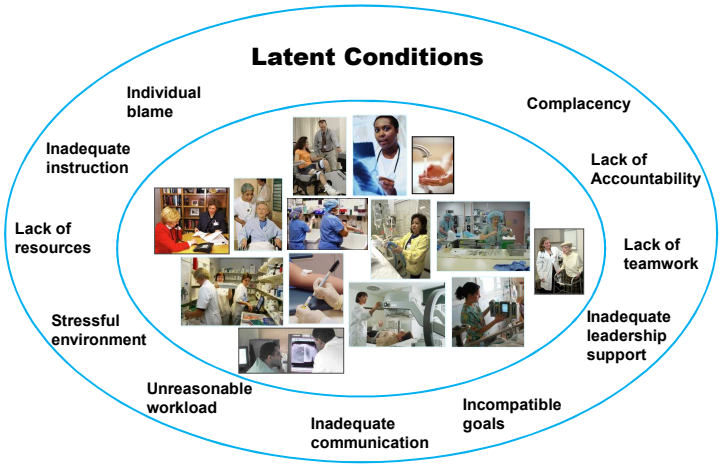
Objectives

- Why a renewed quality effort is needed
- Building the will
- Creating the way

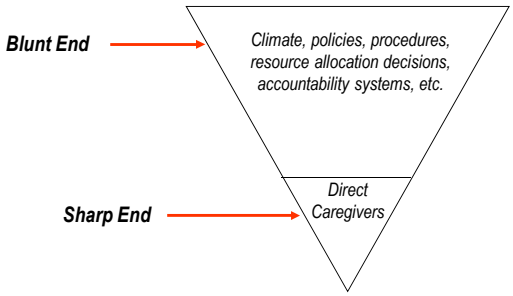
It's Not that We Haven't Been Busy Trying to Prevent Mishaps …

- Benchmarking
- Case management
- Six Sigma Projects
- Nursing Audits
- Quality Circes
- Monitor important aspects of care
- Concurrent chart review
- P-D-C-A improvement projects
- Physician Peer Review
- Clinical Paths
- Occurrence Screening
- Total quality management
- Outcomes Management
- Root Cause Analysis
- Strategic performance goals
- Rapid cycle improvement projects
- Lean Projects
- Failure mode and effects analysis

The "Soil" Sets People Up for Unsafe Acts



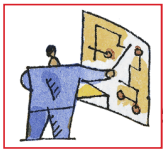
Blunt End Conditions Aren't Resolved by Sharp End Actions Alone



Improving Patient Safety: What Does it Take?

The Will

and



The Way

"Will" Starts at the Board Level

- Boards make an enormous difference
  - TGI/Solucient Top 100
    - The CEO is held accountable for quality and safety goals
    - The board participates in the development of explicit criteria to guide medical staff credentialing and privileging
    - The Board Quality Committee annually reviews patient satisfaction scores
    - The board sets the board agenda for quality
    - The medical staff is involved in setting the agenda for the board's discussion surrounding quality

Lockee, Kroom, Zablocki, and Bader, 2006. *Quality*. The Governance Institute

"Will" at the Senior Leadership Level

- Top-performing hospitals have a striking degree of motivation and commitment to ensuring high-quality care and fulfilling the quality mission. This commitment is reflected in and nurtured by:
  - active leadership and personal involvement on the part of the CEO, other top managers, and the Board of Trustees
  - an explicit quality-related mission and aggressive quality-related targets
  - standing and ad hoc quality committees
  - regular reporting of performance indicators with accountability for improved results
  - promotion of a safe environment for reporting errors

Silow-Carroll, Kutyla, Stepnick, and Rybowski. 2004. *Hospital Quality: Ingredients for Success – Overview and Lessons Learned*. Commonwealth Fund.

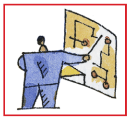
The Way: Six Things Board and Senior Leaders Can Do

1. Setting aims
   - Make an explicit, public commitment to measurable quality improvement
   - Set a specific aim to reduce harm this year

Public Commitment: We will offer all the care and only that care that we know will help you. We will do nothing that will harm you.

Specific Aim: Achieve zero central line infections for the entire institution across all services by August 31, 2014.

The Way



2. Getting data and hearing stories
   - Select and review progress toward safer care as the first agenda item at every board meeting
   - Ground the work in transparency, putting a "human face" on harm data
   - Engage with patients and families
   - Tools: chart audit; case study of a specific case

Tools: IHI Recommendations

- Initial Chart Audit for Harm
  - Review 20 randomly chosen patient charts from the prior month to document all types and levels of injury
    - To best learn about patterns of harm, start the review with a focus on 20 charts from the medical surgical services, or 20 readmissions, or 20 deaths, rather than routine OB cases
- In-Depth Case Study
  - The CEO, with the assistance of the CMO and CNO, should conduct a detailed, personal investigation of a significant patient injury in the hospital, including interviewing the involved patient, family, and staff.

The Way

3. Establishing and monitoring system-level measures
   - Identify a small group of organization-wide "roll-up" measures of patient safety
   - Continually update them
   - Make them transparent to the entire organization and all of its customers

Examples of System-Level Measures

- Rate of Medical Harm per 100 Admissions
- Rate of Medical Harm per 1000 Patient Days
- Hospital Standardized Mortality Ratio (Observed deaths / Expected deaths)
- Inpatient satisfaction (% of recently discharged medical patients who give the hospital the highest possible quality rating)

The Way

4. Changing the environment, policies, and culture
   - Commit to establish and maintain an environment that is *respectful*, *fair* and *just* for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error

The role of leaders in every organization is not to find fault or place blame, but to analyze why people are behaving as they are.

The Way

5. Learning
   - Starting with the board and senior leaders, develop capabilities
   - Set an expectation for similar levels of education and training for all staff

If the pace of change is too slow (taking many months) reconsider the adequacy of your educational and support systems

The Way

6. Establishing executive accountability
   - Oversee the effective execution of a plan to achieve your aims to reduce harm
   - Include executive team accountability for clear quality improvement targets
     - Include management level accountability

Board

CEO

Senior Management Team

Managers / Supervisors

Manager Accountability Scorecard

Responsibility	Evaluation
Provide adequate staff	▪ % of shifts that lacked adequate staff (as defined by staffing plans) ▪ Monthly average of paid overtime hours for direct patient care staff
Promote patient safety improvement activities	▪ # of proactive patient safety improvement projects completed annually
Support a patient-safe culture	▪ # of leadership walk-arounds conducted ▪ Rate of incident/near reporting ▪ Results of culture surveys
Ensure staff are trained to safely conduct their job assignments	▪ # of patient incidents caused by lack of staff knowledge/training ▪ % of staff provided job-specific safety training prior to start of job assignment
Provide adequate rest time for staff	▪ % of staff who get regularly scheduled 10- to 15-minute complete breaks from work
Correct known safety concerns	▪ % of action plans implemented by target date ▪ Timeliness of implementation of "best practice" patient safety recommendations

Leaders Make an Enormous Difference

- Setting Aims
- Getting Data and Hearing Stories
- Establishing and Monitoring System-Level Measures
- Changing the Environment, Policies, and Culture
- Learning… Starting with the Board
- Establishing Executive Accountability