The Leadership Triangle

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Joint Commission on Accreditation of Healthcare Organizations

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Components in Hospitals

- Governing Body
- Hospital Administration
- Organized Medical Staff

Collaborative Roles & Responsibilities

- Mission
- Vision
- Planning
- Direction
- **Quality & Safety**
- Improvement
- Growth
- Survival
- Community

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What do all patients seek?

- Answer: Quality
- Macro-Indicators of Quality
  - Relief of suffering
  - Restoration of function
  - **Safe Treatment**
  - Satisfaction
  - Value

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Job One - Safety

- "Primum Non Nocere."
    - There can be little claim of 'quality' if I'm dead or disabled as a result of care or treatment
    - Developing new products and services in an unsafe organization could be negligent
    - Organizational growth and survival is threatened more by poor safety performance than by any other performance parameter
    - Financial performance and integrity ultimately depend on safe treatment
    - Trustees bear a fiduciary responsibility

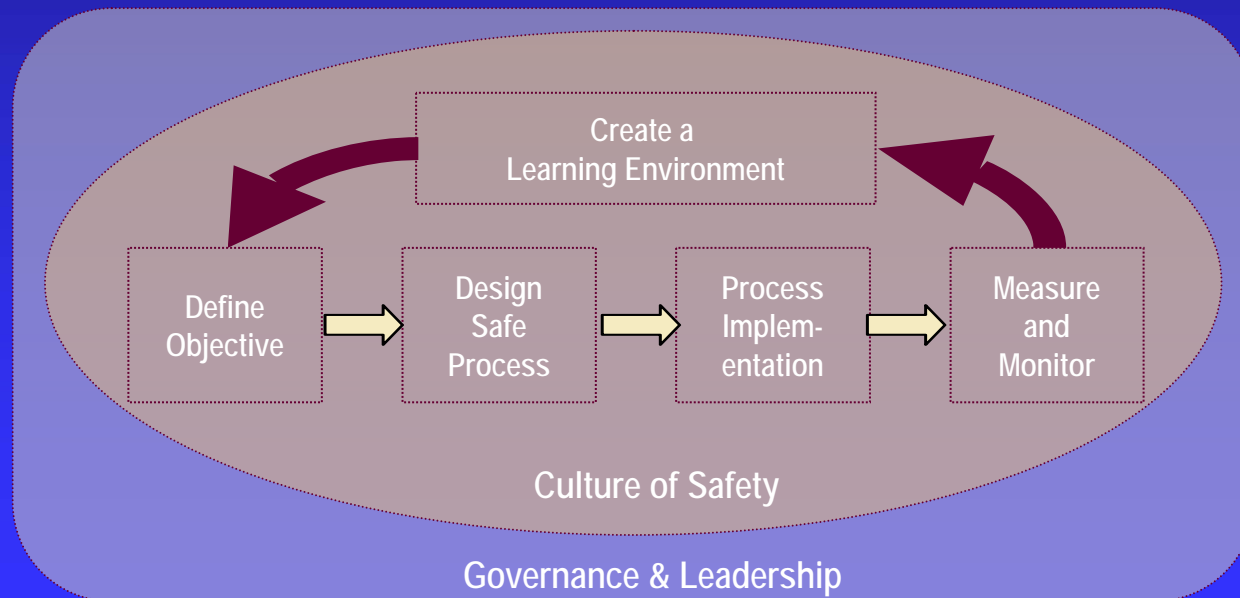# Leadership's Specific Major Functions In Support of Quality & Safety

- Resources
- Personnel
- Time
- Information systems
- Training
- Integrated patient safety program
- Sentinel event identification and management
- Proactive FMEA

- Planned, systematic, organization-wide approach to process design and performance measurement, analysis and improvement
- Leaders to measure and assess the adequacy and effectiveness of their contributions to improving performance and improving patient safety

Patient Safety Model

Model for the Safe Healthcare Delivery Organization

The patient safety model, based in High Reliability Organizational Theory, was developed for improving the safety of care within healthcare organizations. This model consists of the seven components below that organizations must put into place to establish a comprehensive patient safety program.

Create a
Learning Environment

Define Objective → Design Safe Process → Process Implem-entation → Measure and Monitor

Culture of Safety

Governance & Leadership

From David Classen, 2002

Accountability

- Human error is here to stay – IOM I recognized this
- Errors can't be eliminated, but <u>often</u> their harmful effects can be eliminated or mitigated.
- **In such cases, trustees, together with management and the medical staff, are responsible and accountable if the organization's culture, environment and/or process design could but fails to prevent or minimize health care related injury from unintentional human error.**
- National Quality Forum's position.

The Paradox

- First, do no harm

- To err is human

What is the current status of American healthcare?

- Advanced on a world wide basis
- High tech
- High cost
- And yet…
  - Variable practice
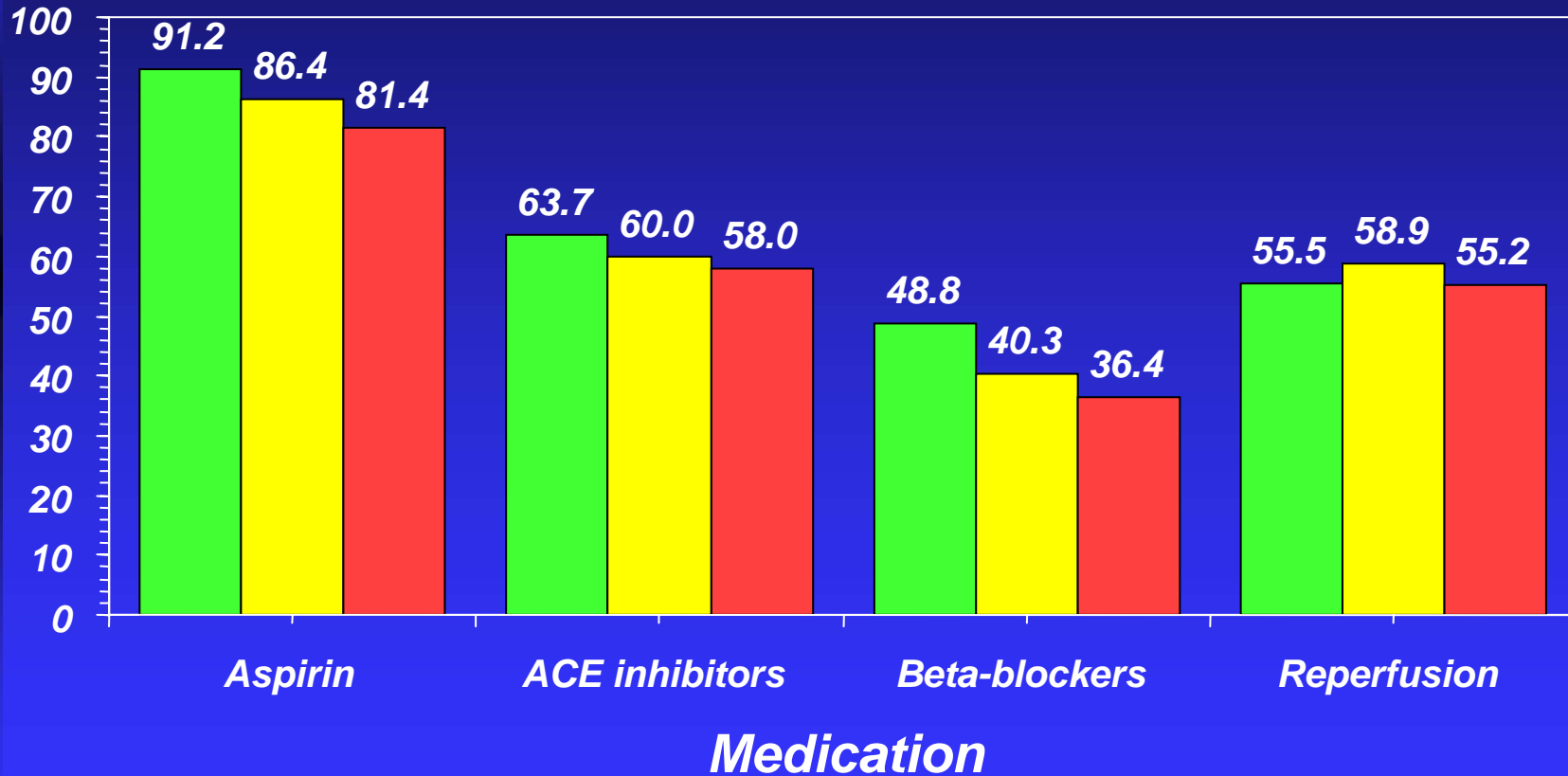 - Variable outcome
  - ***Unacceptable error and injury rate***

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Variability in Practice and Outcome

IHC

% "ideal patients" receiving

Legend:
- ■ *Major teaching* (green)
- ■ *Minor teaching* (yellow)
- ■ *Nonteaching* (red)

Medication	Major teaching	Minor teaching	Nonteaching
Aspirin	91.2	86.4	81.4
ACE inhibitors	63.7	60.0	58.0
Beta-blockers	48.8	40.3	36.4
Reperfusion	55.5	58.9	55.2

Medication

Allison JJ *et al*. Relationship of hospital teaching with quality of care and mortality for Medicare patients with acute MI. *JAMA* 2000; 284(10):1256-62 (Sep 13).
Reproduced with thanks to & permission of Brent James, MD IHC

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Unacceptable Injury Rate

- **1990s Harvard studies**
- **1995 Sentinel Events**
- **1999 IOM "To Err is Human"**
  - ◆ 44,000-98,000 die annually from preventable errors
- **2004 Health Grades study**
  - ◆ 195,000 deaths per year

Why Things Go Wrong

- **Usual proximate causes**
  - ◆ Human error
  - ◆ Equipment failure
- **Underlying causes**
  - ◆ System design

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SYSTEM = parts of a whole

TALL SILOS Of Patient Care

- Admissions system
- Laboratory system

Radiology system

Communication system

Patient transfer system

Etc.

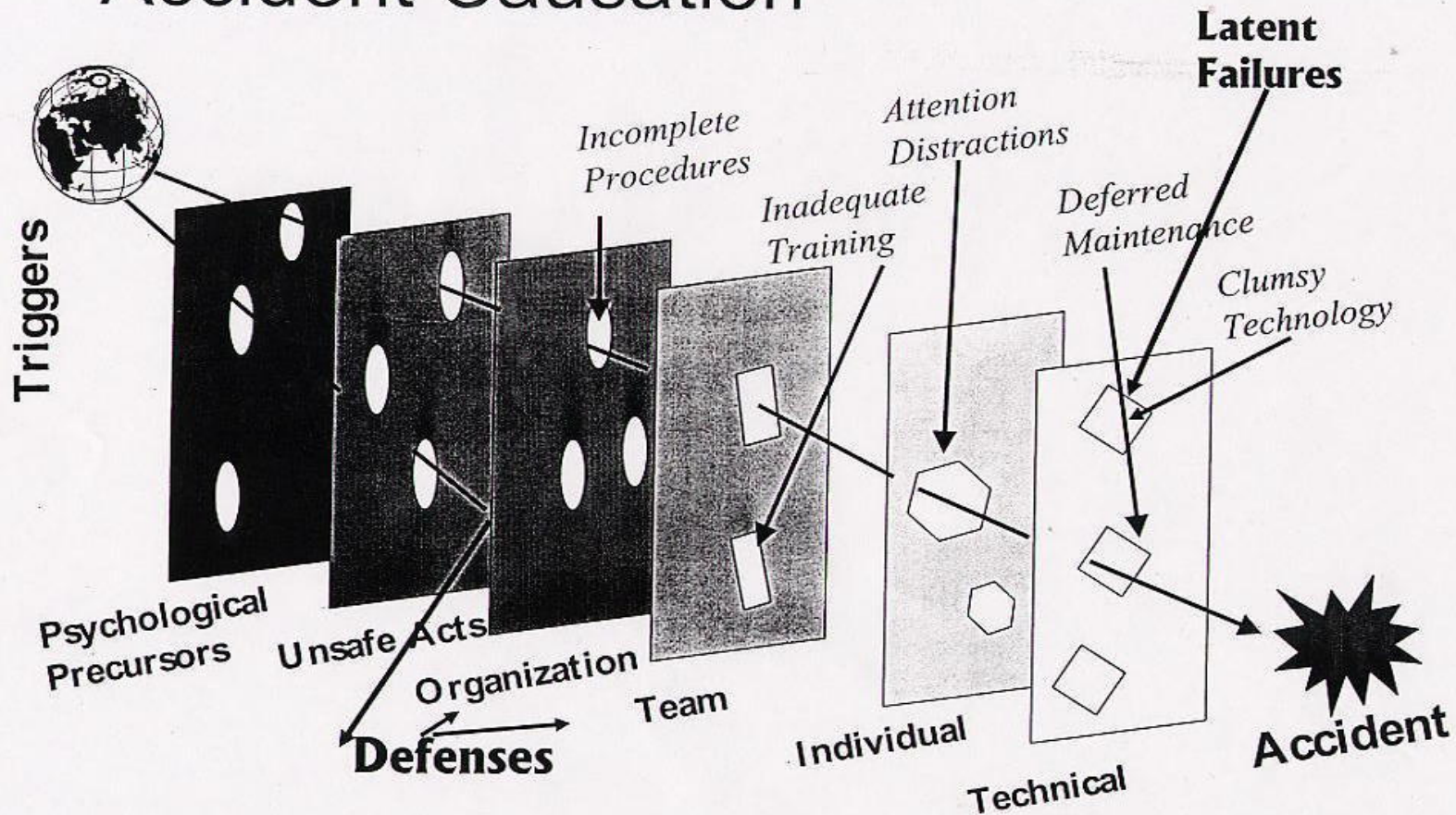Interdependencies exist in the relationships between these systems.

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System Failures

- Force errors
- Enable errors
- Don't prevent errors
- Don't prevent harm

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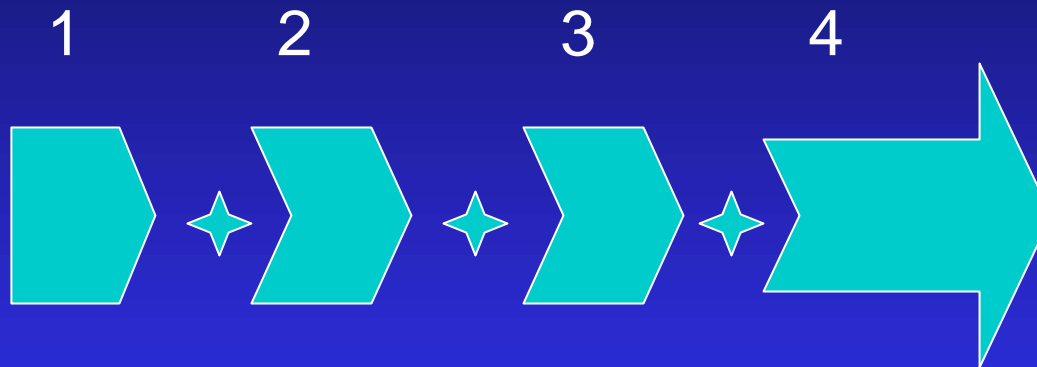Accident Causation

Modified from Reason, 1990

Process & Outcome Control

Process Steps

1   2   3   4

A   B   C

Process Outcomes
(Micro – Indicators)

R
R
S
S
$

Patient Outcomes
(Macro - Indicators)

Attributes of High Risk Endeavors

- Variable input
- Complex
- Non-standardized
- Tightly coupled
- Time restraints
- Hierarchical <u>vs</u> team
- Human intervention

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The Role of Complexity

Success Probability of a Single Step

Number of Elements	0.95 (Desired Probability)	0.99 (Desired Probability)
1	**0.95** (Actual)	**0.99** (Actual)
25	**0.28** (Actual)	**0.78** (Actual)
50	**0.06** (Actual)	**0.61** (Actual)
100	**0.006** (Actual)	**0.37** (Actual)

Learning from Others

- **High risk endeavors**
  - Opportunity for error
  - Serious consequences
- **Examples**
  - Nuclear power
  - Airlines
  - Flight decks
  - Chemical

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Engagement in Performance Improvement

Leadership begins at the top. You set the tone and the priorities. You are in the best position to make a difference. Without a committed, collaborative and well aligned Leadership Triangle, nothing significant happens.

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Prioritization

- A critical role for the Leadership Triad
- Resources are limited
- Choices guided by mission, vision, values & good business practices
- Key to success
- Should be data driven where possible
- Regular reevaluation necessary
- Success depends on the relationships

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Obstacles to Success

- Non-aligned incentives
- Conflict of interest
- Poor communication
- Lack of trust
- Personal or personality issues
- Putting self-serving needs of any component before patient care or organizational success (Violating the 'Yo Mamma Rule')

How Should the Triangle Function?

- As ONE when it comes to safety and quality
- Patient-centered
- Data driven
- Aligned with mission, vision and values of the organization
- As a role model for all staff

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Critical Principles

- Each leadership component is engaged in the development of and aligned with the mission, vision and goals of the organization, and is invested in the organization's success.

- Leadership meets the needs of the population served.

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Critical Principles (cont.)

- Leadership works in partnership to develop communication and other processes that enable resolution of issues and concerns in a consistent and timely manner.

- Each leadership component brings forth and shares relevant information to facilitate evidence-based decision making.

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Critical Principles (cont.)

- Every leader recognizes that mutual respect and civility are paramount to the organization's success, demonstrates these qualities in all of his/her undertakings, and fosters them throughout the organization.

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Critical Principles (cont.)

- In order to fulfill their roles, every leader is competent in each of the following:
  - Assessment of processes from a systems-based perspective.
  - Clinical, strategic and managerial evidence-based decision making, to include legal and financial issues.
  - Integrated decision-making based on team building, collaboration, and open communication.
  - The ability to surface and resolve conflict.
  - The additional core competencies specific to their respective leadership component, as determined by the organization.

Critical Principles (cont.)

- Leadership collaboratively assesses, develops and maintains the skills and effectiveness of individual leaders in the above competencies.

- Leadership collaboratively determines and understands the accountabilities of each component, and the interdependencies between each of the components in fulfilling their respective responsibilities.

Critical Principles (cont.)

- Leadership collectively determines which component would make a final decision where there is not mutual agreement on the resolution of a specific issue.

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There is Light at the End